INDIANA MEDICINE

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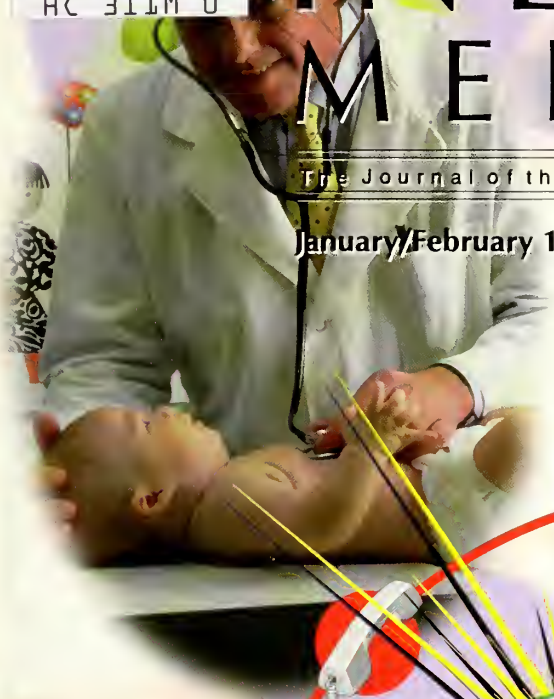

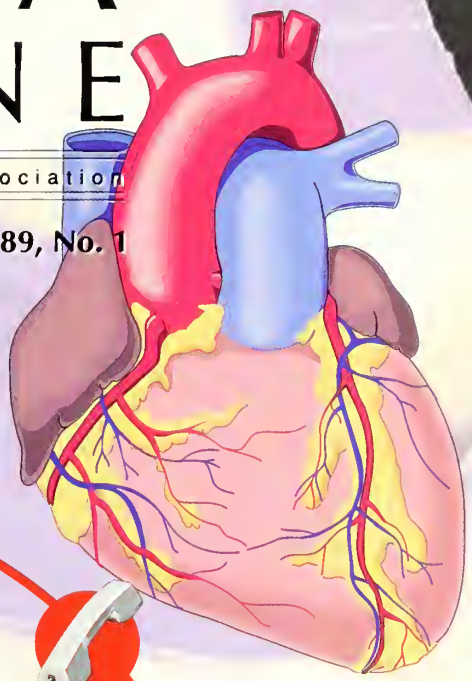

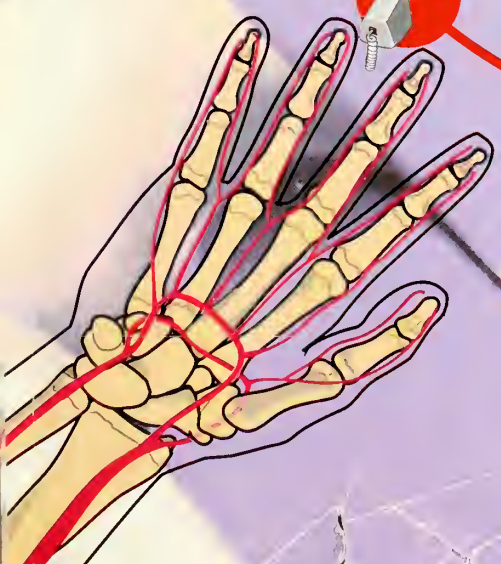

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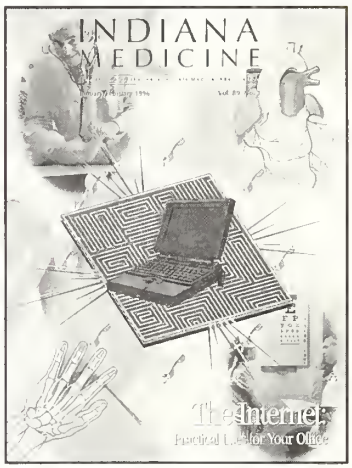
features

scientific contribution



Cover story begins on page 12. Cover design by Greg Albright of Influx Design Communications, Indianapolis.

departments

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State legislative committee begins investigating EDS

A state legislative committee has begun investigating the problems that health care providers are having with Medicaid claims processed by Electronic Data Systems (EDS). The Medicaid Reimbursement Investigative Committee was created by the Legislative Council of the General Assembly.

For months, physicians and other health care providers have encountered significant delays and errors in Medicaid reimbursement, resulting in bankruptcy in some cases.

The committee will study whether EDS has properly performed the terms of its contract with the state Indiana, determine what legislative and administrative procedures are needed to eliminate Medicaid reimbursement backlogs, delays and errors and investigate any other matter related to Medicaid reimbursement and processing of claims. Sen. Pat Miller, R-Indianapolis, is chairman of the committee.

The committee must make and report any recommendations for proposed legislation to the General Assembly before Feb. 17. The state's contract with EDS will expire at the end of 1996, so the re-bidding process must begin in February. The state then would have two options: open bidding to new contractors or renew EDS's contract for one or two years. If EDS's contract is renewed, the state would renegotiate the terms of the contract, adding more specific responsibilities and stricter penalties if those responsibilities are not met.

Leadership conference open to medical society officers

Spokesperson training and a constituent skills workshop will be offered during ISMA's Leadership '96 Conference. The conference is open to officers of state, county and district medical societies, the ISMA Alliance, the Resident Medical Society and the Medical Student Society. It will be from 8:30 a.m. to 4:30 p.m. Saturday, Feb. 10, at the University Place Conference Center on the IUPUI campus in Indianapolis.

Pat Clark of the American Medical Association will conduct the spokesperson training, which is designed to provide participants with the fundamental skills necessary to speak to groups or do radio, newspaper or television interviews.

Michael E. Dunn, president of Michael E. Dunn & Associates Inc., a public affairs consulting firm based in Washington, D.C., will present the constituent skills workshop. He will discuss how to write an articulate letter that will get your legislator's attention and how to make your representative telephone you for your opinion.

For more information, call the ISMA, (317) 261-2060 or 1-800-257-4762. ⌟

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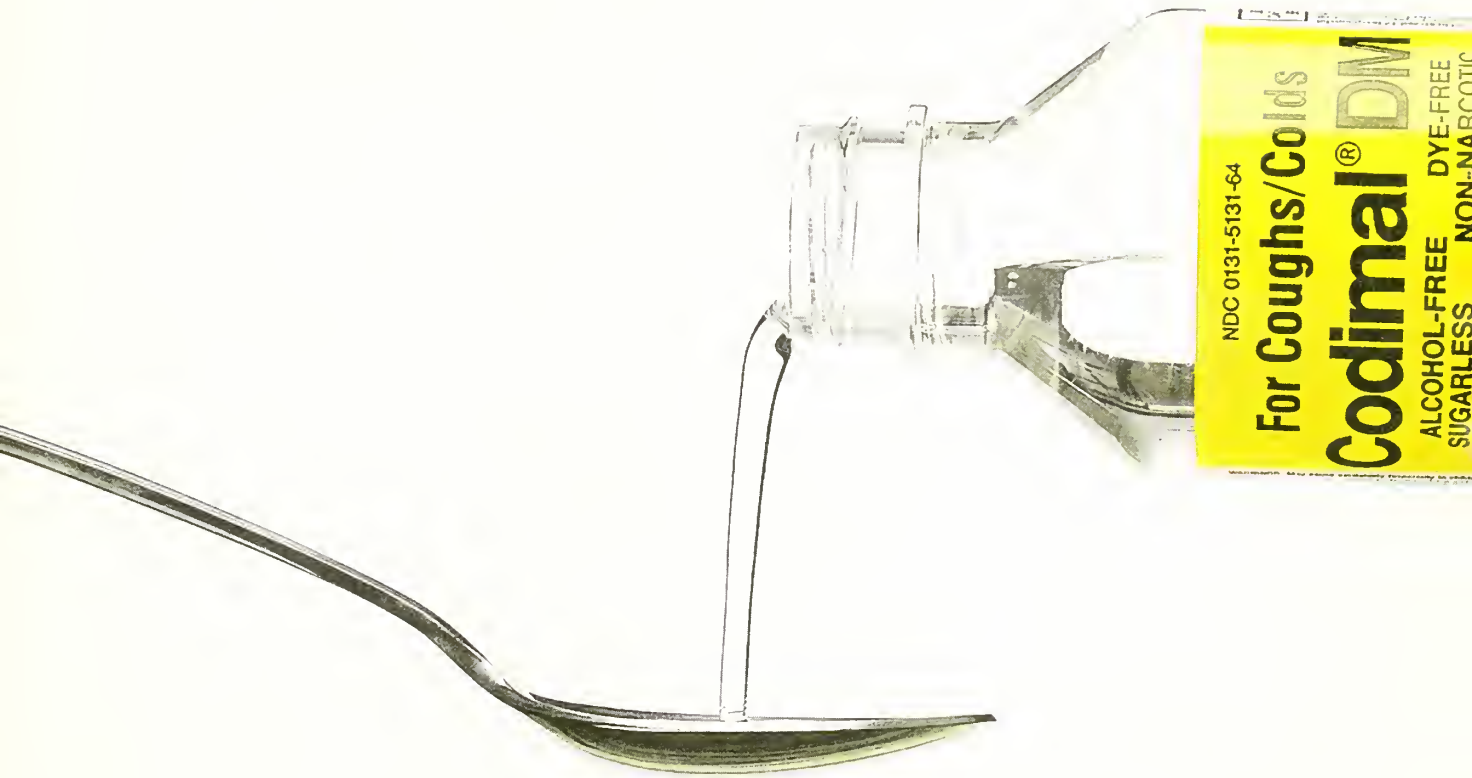

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editorial

George T. Lukemeyer, M.D.
Indianapolis

Recently I was invited to give a Grand Rounds presentation on "The Essence of Professionalism" at St. Vincent Hospital in Indianapolis. In preparing for the talk, I came across the "Patient-Physician Covenant" statement prepared by a distinguished group of physicians and published on the Policy Perspectives page of the May 17, 1995, issue of *The Journal of the American Medical Association.* Recognizing that the pressures and time constraints of a busy practice may have allowed this to slip by you unnoticed, we are pleased to reproduce it here.

It is my firm conviction that the patient-physician covenant is the essence of professionalism. In this tumultuous time of change, I recommend the following statement for your careful consideration:

Patient-physician covenant

Ralph Crawshaw, M.D.
David E. Rogers, M.D.
Edmund D. Pellegrino, M.D.
Roger J. Bulger, M.D.
George D. Lundberg, M.D.
Lonnie R. Bristow, M.D.
Christine K. Cassel, M.D.
Jeremiah A. Barondess, M.D.

Medicine is, at its center, a moral enterprise grounded in a covenant of trust. This covenant obliges physicians to be competent and to use their competence in the patient's best interests. Physicians, therefore, are both intellectually and morally obliged to act as advocates for the sick wherever their welfare is threatened and for their health at all times.

Today, this covenant of trust is significantly threatened. From within, there is growing legitimation of the physician's materialistic self-interest; from without, for-profit forces press the physician into the role of commercial agent to enhance the profitability of health care organizations. Such distortions of the physician's responsibility degrade the physician-patient relationship that is the central element and structure of clinical care. To capitulate to these alterations of the trust relationship is to significantly alter the physician's role as healer, carer, helper and advocate for the sick and for the health of all.

By its traditions and very nature, medicine is a special kind of human activity – one that cannot be pursued effectively without the virtues of humility, honesty, intellectual integrity, compassion, and effacement of excessive self-interest. These traits mark physicians as members of a moral community dedicated to something other than its own self-interest.

Our first obligation must be to serve the good of those persons who seek our help and trust us to provide it. Physicians, as physicians, are not, and must never be, commercial entrepreneurs, gatekeepers or agents of fiscal policy that runs counter to our trust. Any defection from primacy of the patient's well-being places the patient at risk by treatment that may compromise quality of or access to medical care.

We believe the medical profession must reaffirm the primacy of its obligation to the patient through national, state and local professional societies; our academic, research and hospital organizations; and especially through personal behavior. As advocates for the promotion of health and support of the sick, we are called upon to discuss, defend and promulgate medical care by every ethical means available. Only by caring and advocating for the patient can the integrity of our profession be affirmed. Thus we honor our covenant of trust with patients. ❑

Dr. Crawshaw is in private practice in Portland, Ore.; Dr. Rogers, who died Dec. 5, 1994, was the Walsh McDermott University Professor of Medicine at the New York Hospital-Cornell Medical Center; Dr. Pellegrino is director, Center for Clinical Bioethics, Georgetown University Medical Center, Washington, D.C.; Dr. Bulger is president, Association of Academic Health Centers, Washington, D.C.; Dr. Lundberg is editor, JAMA, *Chicago; Dr. Bristow is president, American Medical Association; Chicago; Dr. Cassel is section chief, Department of Internal Medicine, University of Chicago, Chicago; and Dr. Barondess is president, New York Academy of Medicine, New York, N.Y.*

Correspondence: Ralph Crawshaw, M.D., 2525 N.W. Lovejoy, Portland, OR 97210.

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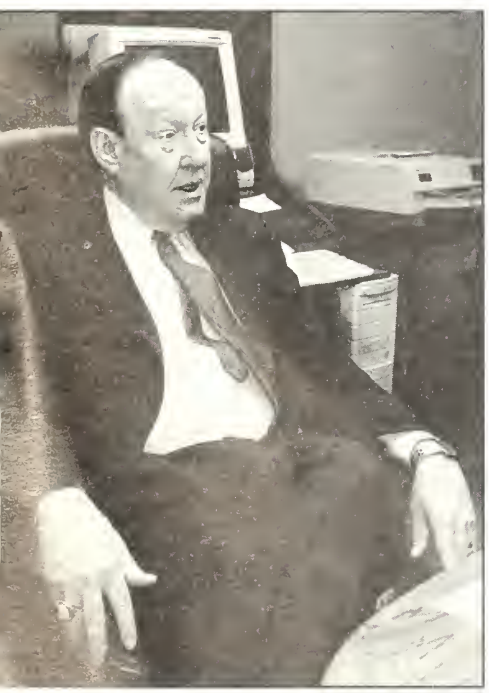
IU dean lists funding

Bob Carlson
Indianapolis



Robert W. Holden, M.D., acknowledges that these are tumultuous times for medicine and smiles with anticipation when he tells you he's looking forward to the challenges. As the new dean of the Indiana University School of Medicine and director of the IU Medical Center, Dr. Holden has his work cut out for him, and he knows it. Federal and state funding is shrinking, research money is harder to come by, and the health care marketplace is becoming increasingly competitive.

He succeeds Walter Daly, M.D., who retired Oct. 31, 1995, after serving as dean and director since 1983.

Dr. Holden, who has been a professor of radiology at IU since 1973, served as chairman of the IU Department of Radiology since 1991. The department implemented a Positron Emission Tomography (PET) program and a teleradiology program under his leadership. In 1992, he was named the Eugene C. Klatte Professor of Radiology, a chair that was established in recognition of his predecessor.

He is past president of the Indiana Roentgen Society and serves on the Wishard Memorial Foundation Board of Directors. He is a fellow in the American College of Radiology and the Society of Cardiovascular and Interventional Radiology. He served on the Board of Scientific Counselors in the Division of Cancer Treatment at the National Cancer Institute from 1990 to 1994 and was a consultant to the National Institutes of Health Radiation Research Program in 1989-1990. He received the Distinguished Alumni Award from the Purdue University School of Pharmacy and Pharmacal Sciences in 1992 and the Bowen Distinguished Leadership Award from the IU School of Medicine in 1993.

In this conversation with *Indiana Medicine*, Dr. Holden talks about his goals as dean, the challenges of medical school funding, the impending changes in medical education, the IU-Methodist hospitals merger and his views of his new job.

Indiana Medicine: Congratulations on your recent appointment as dean. What are your initial reactions after only a few weeks in this position?

Holden: The office of the dean is busy and people are very gracious. Most of the time, they want support or direction for a specific item. Usually, you can facilitate and help them, and other times, you're looking for a very global change which is going to take some reflection and concept-building. Right now, we're in tumultuous times, with lots of change, and people are anxious. I need an understanding of what their problems are and integrate the problems and resources of the school to establish some global goals and directions.

Indiana Medicine: Do you like the job?

Holden: I'm excited about it. It's a big change from where I've been in the past. In radiology, my interpersonal involvement was principally directed towards a product. The dean's office seems, thus far, much more concept-oriented and reacts to external changes rather than being involved in the day to day evolution of a product. The issues are markedly less able to be fixed with

as top challenge

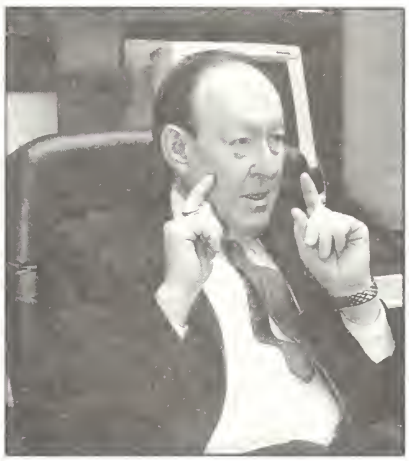
one quick shot.

Indiana Medicine: What accomplishments of Dr. Walter Daly, your predecessor, would you like to build on?

Holden: During his deanship, Dr. Daly saw a dramatic growth in the research elements of the school. From the time he took over 12 years ago, external peer-reviewed research funding for the school increased something like $13 million to $90 million, which is truly dramatic growth. I think we have seen a maturation of a research infrastructure which is truly outstanding. I would like to see that continued and solidified in the face of what I believe will be increasing challenges. I think research funds will be harder to obtain in the future. Society is looking for improved cost-efficacy in health care, education and research, and the medical school will be under challenge to enhance our efficiencies in all aspects of our practice.

Indiana Medicine: Why will research funds be harder to obtain?

Holden: One of the reasons is that health care purchasers, be it employers or insurance companies, are looking for more product and more cost-efficient delivery. They want to buy more and pay less, basically, just like any other consumer. In the past, we have been cost-based in our reimbursement. Whatever it cost, people were willing to pay. Today, people are asking us to significantly decrease our cost, and there's not been that thrust in the past in medicine. If someone was sick, the prevailing philosophy was let's give them the very best that we can. We were not



willing to accept any sort of cost constraints. Today, there's a global societal belief that we can't afford the absolute best for everybody and we've got to figure out where we're going to be more cost-effective. On the other hand, we're not willing to accept that for our mother and father or our family, and so I think that is the major challenge for us.

Indiana Medicine: What are your goals as dean?

Holden: When I was speaking to the medical student council a couple of days ago, I said you are the reason we're here. Medical students are the reason we have medical schools. We are interested in promoting the highest quality education for the medical student. To do that, you need a research component, and you need a robust clinical care component or, in other words, patient base. If you don't have those, you can't produce a product that is going to provide optimal care to the citizenry of Indiana today and in the future. Medical students need to see patients. They need to see pertinent research that's being done today because today's research is truly tomorrow's practice. If you don't keep them on the front edge, then their education is going to suffer in comparison to other medical schools. So it's really the integration of this totality of patient service, research and education that makes a good medical school.

Indiana Medicine: What are the challenges facing the IU School of Medicine and all medical schools?

Holden: Funding is obviously the major challenge for the medical school today and tomorrow. If you look across the country, 80% of medical schools and their allied teaching hospitals are in some sort of dramatic change – integration with for-profits or with other not-for-profit structures – such as we're doing with Methodist. They're doing that to maintain an income sufficient to allow them to shift costs associated with medical education and to be competitive in the health care marketplace. If they don't have a fairly large volume, or if they don't have endowed funds or philanthropy, then they are really not going to be able to survive in the future in their current structure. We are in a dramatic sea of change.

Indiana Medicine: Any other challenges, or is that one so overwhelming that all the others are small by comparison?

Holden: There's a challenge of becoming more efficient. In the educational sector, in the research sector and in the clinical care sector, we must become more cost-effective. Therefore we must be more

efficient with time and materials. Traditionally, most of our services are labor-intensive, about 50% personal services. That component is driven predominantly by people and the expenses of salaries. I see this impacting the areas of research, teaching and clinical services, which will all become more segmented and more specialized, so that people can be more efficient in what they do because they do it more often and more repetitively. In the past, we've looked at somebody who would be a triple threat, that could teach and could do research and do clinical service. In the future, I think we'll see a more specialized delivery, we'll see people concentrate more on one aspect of their role and not try to do all three.

Indiana Medicine: Who's going to pull it all together?

Holden: Well, that's the dean's and the clinical chairman's job. We can't forsake any one of the three missions. I see that to be the administrative role for our leadership.

Indiana Medicine: What opportunities do you foresee for the IU School of Medicine's Statewide Plan for Medical Education?

Holden: The statewide plan has been very successful. It has brought together the citizenry of Indiana in the acceptance of one medical school for the state. We have proven that regional basic science education is able to produce a quality product at numerous sites. In its 25 years, each site has grown such that it's more facile and better integrated within its parent college or university, such

as Notre Dame in South Bend. Today, each one of the schools is accepted better in its parent institution than it's been at any time. We need to be sure that we markedly facilitate their ability to provide a uniform education equal to others. One of the challenges for us will be to become more communicative. I think that faster transmission for digital information and television is going to facilitate that. Major ATM [asynchronous transfer mode] pipes between our hub and each one of the campuses will dramatically promote our ability to produce a more homogeneous product. The ability to have massive worldwide digital data flow on a very rapid basis, telecommunication such as teleradiology, e-mail or interactive video, will greatly facilitate our ability to reach out to regional centers.

Indiana Medicine: What changes might be made in the curriculum to help train physicians for the 21st century?

Holden: I think society very much wants a change. They want outpatient medicine. They want us to provide access close to their homes. They don't want to travel to downtown Indianapolis to see a physician. We're going to become more ambulatory in services and access to patients. We're going to move away from being only a tertiary care provider. Our students need to learn first-hand with practicing physician preceptors in an ambulatory setting. We do that currently with our junior medical students that go out into the state and preceptor with family practitioners. We'll see more and more of that with a specialty service as well, in pediatrics, internal medicine and obstetrics and gynecology on the primary care front. Without question, we're seeing a change in medical services delivery away from the hospital to ambulatory offices where tertiary care can be provided in a multi-specialty as well as a primary care setting.

You're going to see us move students away from the medical center per se and into a more regional sort of delivery environment. We must educate students in the practice mode in which they're going to practice in the future, and I believe the future of medicine is going to be far more ambulatory than it's been in the past.

Indiana Medicine: Would you like to make any comments on the IU Hospitals-Methodist Hospital merger?

Holden: I am very definitely a supporter of the merger. I see the merger allowing us an in-patient base sufficient for us to train a subspecialist in a hospital setting. With falling hospital censuses and decreasing in-patient days, we're going to see a dramatic shift to the ambulatory. That makes it much

more difficult to have an interdisciplinary patient population for in-house training of subspecialists, and if we don't maintain a large hospital setting, we'll lose our ability to provide that education. If, for instance, our 400-bed adult hospital fell to 200 beds, as is happening in California, it will make it difficult to have enough patients to train subspecialists, and specifically, it makes it difficult to have the consulting role that we believe subspecialists need to produce a high quality product in an extremely complex case. With the consolidation of Methodist and IU, we believe that the patient base will be sufficient to maintain this educational arena. And that's our principal reason for wanting to do this. Plus, we'll be a more cost-effective health care provider.

Indiana Medicine: Would you discuss the importance of philanthropy to assure excellence in teaching, research and advanced patient care in these times of fiscal constraint?

Holden: As I mentioned before, if the clinical revenues which we currently use to offset the educational cost addition to patient care are not present, and we can't cost-shift from the research arena because of falling research funding, we must turn somewhere to finance the enhanced costs of an educational environment. We really have only two revenue sources: one, taxes, because of the state role that we play; or two, philanthropy. And since the Indiana public and the American public in general are not tending towards increasing taxes at the present time, philanthropy is really one of the major ways that we see as an available escape for equalizing the private sector versus an academic sector cost for health care training. Under the leadership of Dr. David Smith, we have just undertaken a major capital fund drive which has raised more than $150 million for the medical school within the past three years. That's a truly remarkable amount and allows us to endow financial support for teachers and researchers and to offset a portion of their salaries. Thus, the costs for teaching and research are decreased, and this promotes the retention of outstanding teachers and researchers in an educational environment and allows us to be on a more level playing field with clinical care costs.

Indiana Medicine: Is philanthropy for medical schools a nationwide trend?

Holden: Yes, philanthropy is becoming much more important and certainly is much more mature in our institution. IU is becoming increasingly well-known throughout the country for the quality of our graduates, and our graduates feel proud of this and are more willing to give to the school, as are satisfied patients. With excellence comes reward.

Indiana Medicine: What would you like to leave as a legacy of your tenure as dean?

Holden: I would like to see us be able to come through these times of challenge with a stronger, more integrated school, providing uniformity in all aspects of its mission; a teaching unit providing a tighter integration of the centers with the school through better communication channels; a research structure and patient care delivery services that are responsive to the demands of a modern society. Medical education has not changed very much in the last 50 years. We've worked on perfecting what we have been able to do. Society is demanding a change, and I think we must change. The next five years will see dramatic change in our educational processes and it's my desire to not lose quality but enhance quality during this change.

Indiana Medicine: Any other issues that you'd like to share with your colleagues at this time?

Holden: Times are changing. There is anxiety and stress, but we are looking forward to the challenges. Stressful times promote access to leadership and leadership's ability to manage, and I would hope that we can be even stronger in the future with an outstanding school. ❑

Bob Carlson is a health care writer based in Indianapolis.

The Internet: Practical uses for your office

Bob Carlson
Indianapolis

Thanks to the Internet, you can check on the status of a new pharmaceutical at the FDA in Washington, D.C., and a few seconds later, e-mail a colleague at Austin Hospital in Melbourne, Australia, all from the comfort of your home or office.

The Internet is a network of millions of computers that link users from throughout the world. Actual statistics on Internet users are hard to come by because the numbers are increasing so rapidly. One thing is certain: tens of millions are on-line and the number is growing by the thousands every day.

In response, the computer industry is now coming out with less complex, cheaper personal computers designed not to run spreadsheet or graphics software, but simply to get on the Net. For the first time, the Internet and information-sharing technology totally dominated Comdex '95, the industry's biggest trade show. The personal computer used to be an information processing device. Now it is also becoming a communication tool.

It's hard to overstate the Internet phenomenon, not only because of its unprecedented growth, but because it's all-pervasive and it's global. Government agencies, business entities, the military, academic institutions and professional associations – from around the country and around the world – are on-line. You can riffle through on-line versions of such publications as *The Wall Street Journal*, many American Medical Association publications, the *Journal of the National Cancer Institute*, the *New England Journal of Medicine* and the *Morbidity and Mortality Weekly Report*. You can access electronic bulletin board systems, news groups and listervs on every conceivable topic. You will also find shopping, commerce, news, advertising, entertainment and games.

With virtually anybody and everybody on the Net, subscribers now have access to more information and interactive communication than anyone wants or needs. Or, to put it another way, if the Indianapolis-based Bob and Tom morning radio program has a home page on the Internet, can the Internet possibly be of any practical use to Indiana physicians?

To find out, *Indiana Medicine* talked to five practicing Indiana physicians who have been using the Internet. First, however, to appreciate their comments, advice and caveats, here's a brief introduction to the Internet. (Also refer to glossary on page 13 and list of resources on page 15.)

How did it begin?

Before there was an Internet, there was the Advanced Research Projects Administration network, or ARPANET. Begun in 1969, ARPANET linked the U.S. Department of Defense, military contractors and academic institutions involved in military-funded research. It was designed to withstand nuclear attack by rerouting communications through surviving links. The principle that every terminal in ARPANET could communicate with every other terminal is the concept that evolved into the Internet.

The Internet is really a large network of smaller university, business, military and science networks in the United States and other parts of the globe. It consists of LANs (local area networks), MANs (metropolitan area networks) and WANs (wide area networks). Most personal computers are connected to the Internet through a university, through one of the major commercial on-line services or through a local Internet access provider (using ordinary telephone lines and modems).

On-line service providers such as America Online or CompuServe are independent commercial entities that market an appealing menu of interactive computer services to subscribers who pay a monthly fee. Most of these services include Internet access as one item on their menus.

What can it do?

What you can do on the Internet falls into three basic categories. Electronic mail, or e-mail, is the most commonly available and most frequently used Internet service. E-mail is fast, it eliminates phone tag, it simplifies documentation, and it lets your computer do the filing. E-mail applications also include electronic bulletin board services (BBS), subscribed mailing lists and listservs, all of which facilitate electronic communication ranging from gossip to professionals talking shop.

The second basic Internet service is remote log-in (telnet), which allows you to browse a remote computer. This is the Internet application you would use to access the dermatology database at the

University of Erlangen in Germany, which includes full color images of various skin conditions. At home after dinner, you would use remote log-in to browse through "Glasnost," an on-line exhibit of documents from the former Soviet Union at the Library of Congress.

The third basic service on the Internet is file transfer (ftp). This is the Internet application you would use to download a file from another computer onto your computer. If the file represents a substantial chunk of data, such as a full color image, it may take minutes to download, depending on the bandwidth of the transmission line and the speed of your modem.

Navigating the Net

An electronic database can sometimes be accessed in several ways, some of which bypass the Internet. If you have an account with the National Library of Medicine (NLM), for example, you can search its 7 million item Medline database by dialing an 800 number that connects your computer directly to the NLM computer. The entire NLM database is also available on CD-ROM. If you subscribe to CompuServe, which provides Internet access, you can access Medline through Paperchase. Physicians' Online, sponsored by pharmaceutical firms and managed care organizations, is accessible at no charge to physicians on the Internet and offers unlimited free Medline searching.

Navigating on the Internet is becoming more efficient and less time-consuming, thanks in part to the World Wide Web (WWW) and navigation tools (browsers) such as Netscape and Mosaic. A subset of the Internet, the WWW is a search

Internet glossary

The Internet has spawned a new language. Here are definitions of some of the terms used in the accompanying story:

bandwidth: capacity for transmitting digital data; expressed in bits per second, as in 64 Kbps (64,000 bps) or 1.54 Mbps (1,540,000 bps).

BBS (Bulletin Board System): a software program that accepts connections and provides services such as e-mail, distributed conferencing, database access, file transfer and on–line chatting.

CD-ROM (Compact Disc-Read Only Memory): digital compact disc used to store large collections of data, such as reference materials.

download: to transfer an electronic file from one computer to another computer's hard drive.

ftp (file transfer protocol): a standard for sending files from one computer to another computer.

hypertext: text in a computer document that contains embedded links to another document on the World Wide Web.

informatics: a field of study about problems and issues in communications and computer technology.

listserv (listserver): software programs which manage computer mailing lists; also referred to as discussion groups.

modem (MOdulator/DEModulator): converts digital data to analog signals and vice versa: used to transmit digital data over telephone lines.

multimedia: documents that include data in different forms, such as text, sound and images.

Netscape: popular Web browsing software.

server: a computer that provides a service to other computers in a network.

Telnet: a standard for accessing a remote computer system.

WWW (World Wide Web): growing part of the Internet that uses hypertext. ❑

system that uses hypertext to link related topics. A mouse-click on hypertext, which is usually displayed in blue, automatically displays one or more new Web sites related to the topic in the text. More and more Web data are also available in multimedia form, including information in audio and video form. Not surprisingly, the Web is growing at warp speed.

Some physicians already have Internet access through the hospital or academic institution where they work. Many more are logging onto the Internet on their own. As many as 30% of all Internet users may be physicians. In some parts of the country, physicians are already using e-mail to renew prescriptions, make referrals, handle questions about minor ailments and communicate test results to their patients.

Here's what some Indiana physicians are doing on the Internet.

William Cordell, M.D.
Director of Emergency Medicine Research and Informatics
Methodist Hospital
Indianapolis

After the speed of the Massachusetts Institute of Technology server, the 14.4 Kbps modem he uses back home in Indiana was somewhat of a letdown. He was spoiled, says Dr. Cordell, by his first experience with the Internet as a National Library of Medicine Fellow in June of 1994. Since then, he has become an enthusiastic proponent of the Internet for physicians. He describes the Internet as the hottest area in information technology right now and says he has never seen anything proliferate as rapidly.

Dr. Cordell spends most of his time on the Internet doing research in pain management and informatics and communicating with colleagues in the United States and other countries. He has Internet access through Methodist Hospital, which is developing a home page on the Web, and at home through America Online and CompuServe. Dr. Cordell confesses that he also enjoys just browsing the Internet, but warns that it can be addictive.

Because of severe time constraints, consulting the Internet is not yet practical for real-time searches in the emergency department, although Dr. Cordell sees that changing. He does have his computer running in his office next door, however, and participates in a listserv on critical care and emergency medicine. He also uses the National Library of Medicine database, which the Methodist Hospital Library has on a local network computer, accessible by telnet from his office or home.

How can the Internet help a medical practice? His number one use is e-mail. "You can communicate with colleagues rapidly using the list servers, getting into specialty groups that have common interests and throwing questions back and forth," says Dr. Cordell. He is increasingly using the WWW to search for grant opportunities as well as researching clinical topics. He cautions that, except for established sources like the NLM, there is no guarantee about the reliability of much of the information on the Internet.

His advice to physicians is take the Internet seriously for CME and patient care and start viewing computers as communication devices. He also confesses he will be thrilled when his 15-year collection of medical journals becomes available with full text and graphics either on-line or on CD-ROM. "Then maybe my office will stop sinking," he says.

Greg Hindahl, M.D.
Partner, Mount Pleasant Family Practice
Co-Director, Deaconess Hospital Family Practice Residency
Evansville

Although he's been on the Internet for only three months, Dr. Hindahl has been using Physicians' Online, which can also be accessed by dialing in, for over a year. Physicians' Online is sponsored by pharmaceutical companies and managed care organizations and is free to physicians. Dr. Hindahl especially likes the fact that it includes free searches of the National Library of Medicine Medline database, which he has been using a lot. He says he finds information on Medline that may not appear in journals for months. Recently, he was able to enroll one of his patients with sucrase isomultase deficiency, for which there is no medication, in a study being conducted at Boston Children's Hospital. Were it not for Medline, he says he would not have known about the study.

Dr. Hindahl is clearly excited by what he is finding on the Internet. There's an Emory University Web site which offers access to more than 2,000 on-line medical journals and thousands of other medical Web sites, including the National Institutes of Health, the Centers for Disease Control and Prevention and the World Health Organization. He says it took him less than a minute on the Internet to get the CDC's current immunization policies for his residents at Deaconess Hospital. He found a

variety of patient educational materials prepared by the American Academy of Family Physicians that can be downloaded, printed and used by physicians at no charge. He also came across a forum in which several physicians discussed the relative merits of various practice management software programs.

"It's a lot of fun," says Dr. Hindahl, "but probably the best thing about the Internet is that it gives you access to almost anything you need to know within a few minutes."

Some clinical Web sites are limited only to physicians, but most are accessible to anyone on the Internet. Dr. Hindahl believes the dangers of patients trying to diagnose themselves are far outweighed by the benefits of educated patients. He says several of his patients with Internet access have educated him, like the woman who told him about an experimental drug for severe MS.

"I would say after a little bit of experience, it's very easy to use," says Dr. Hindahl. "I can see where the things I'm getting from the Internet are going to allow me to take better care of my patients. There's also a tremendous amount of research, and I'm going to be able to use that with our residents because I'm the faculty member of our research committee."

Lawrence Judy, M.D.
Internal medicine
Welborn Clinic
Evansville

When he has tough questions, Dr. Judy goes to his computer.

He cites the example of a patient with a high eosinophil count and a skin rash. It wasn't clear whether she was having an allergic reaction or whether it was something else. By accessing the National Library of Medicine, he was able to quickly sort through a lot of articles on eosinophilia, a lot faster, he recalls, than trying to find textbooks in the library and going through the indexes. He says it was probably eosinophilic leukemia, and was ultimately fatal.

For that search, Dr. Judy says he used Paper Chase, a search program developed at Beth Israel Hospital in Boston and accessible through CompuServe. He started using Medline through CompuServe in the mid-1980s and also uses the NLM's Grateful Med search program.

With a computer and access to electronic databases, it often takes only minutes to answer a patient's question and stay current on pharmaceutical products. Dr. Judy remembers a patient who brought in a bottle of pills neither he nor his pharmacist recognized. He went to his computer and, using Paper

For more information

Internet Service Providers (ISPs)

There are dozens of ISPs in Indiana, with more popping up every week, that service one or more area codes. For a comprehensive listing of ISPs in your area, call Dean Riddlebarger, general manager of IQuest Internet, an ISP in Indianapolis, at (317) 259-5050, ext. 1. He also has some useful caveats about Internet access for medical offices.

Online service providers

America Online (AOL): 1-800-227-6364
AT&T Easy Link: 1-800-242-6005
CompuServe: 1-800-848-8199
Delphi: 1-800-544-4005
GEnie: 1-800-638-9636
MedWorld: 1-800-633-9532
MCIMail: 1-800-444-6245
Physicians' Online: 1-800-332-0009
Prodigy: 1-800-776-3449

Books

- *The Internet for Dummies* by John R. Levine and Carol Baroudi (IDG Books, $19.99). If the title strikes a chord, this could be a good choice.
- *The Online User's Encyclopedia: Bulletin Boards and Beyond*, by Bernard Aboba (Addison-Wesley Publishing Co., $32.95). Encyclopedic but readable, with a Quickstart section.
- *Physicians' Guide to the Internet* by Lee Hancock (Lippincott-Raven, $29.95). Basic information and a list of medical resources on the Internet.
- *The Whole Internet User's Guide & Catalog* by Ed Krol (O'Reilly & Associates Inc., $24.95). Endorsements by lots of important people. Comprehensive. ❑

Chase, found three articles that confirmed the efficacy of the medication. In less than 10 minutes, he was able to recommend the pills to his patient and send him on his way.

Dr. Judy also accesses the American Informatics Association's forum and the American College of Physicians ACP Online through CompuServe. Like Dr. Hindahl, he dials up Physicians' Online.

"I'm curious and I find it very satisfying to be able to deal with computers as part of daily life," he says. "I think most physicians are generally curious people. They're certainly capable of taking on intellectually challenging topics. Just to become a physician requires a good deal of intellectual effort, and I don't think there's anything about computers that physicians couldn't handle. For some people it may be new, but they can learn if they can see how it benefits them."

James Krueger, M.D.
Internal medicine
Welborn Clinic
Evansville

When he began to explore the Internet almost two years ago, Dr. Krueger's goal was to find out whether it was useful to physicians on a daily basis, so useful that they would prefer it to CD-ROMs or the library.

Although he sees medical information becoming more organized on the Internet, in general, he does not consider it useful to physicians on a daily basis at this time. Still too much chaff and not enough wheat, he says. Rather, he recommends a few good Web sites – Yahoo, Oregon Health Sciences University's Cliniweb, Healthnet from Canada – and e-mail. He also likes the NLM and ACP Online on CompuServe and the listservs MMatrix-L and HMatrix-L on the Internet. For accessing images, he prefers CD-ROMs because of the slow image access time over the wire.

Dr. Krueger spends seven to 10 hours a week on-line and researches specific patient conditions daily in the NLM, which he considers of absolute and immediate use to all physicians. He recommends that, as a first step to exploring the benefits of accessing medical information electronically, physicians open an account with the National Library of Medicine and get a copy of Grateful Med software. Second, physicians should investigate the capabilities of the major on-line services. And finally, physicians can use a browser to explore the World Wide Web where, he says, they will discover things, not necessarily extract them.

"Medicine is no longer about memorization," says Dr. Krueger. "I think we have come to a more mature understanding of the spread and use of knowledge. It shouldn't be considered intellectual failure to say I don't know, I need to go check my resources. The wise person is the one that knows where to find the information, not necessarily one who has memorized all the information. It is incumbent upon us if we are going to properly care for people in an increasingly complex medical world to present the information to ourselves and our colleagues in the most readily accessible format possible. We have to act as the human interface between the person with the illness and the knowledge needed to treat them."

Ram Ravindran, M.D.
Director of OB Anesthesia,
Wishard Memorial Hospital
Indianapolis

Dr. Ravindran admits he is an Internet nut. It's his hobby, what he does to relax, usually for two to three hours a day. The more you search, the more you find, he says, and warns that it's easy to get hooked.

He has been on the Internet for two years and uses it primarily to stay in touch with colleagues, to make new contacts and to correspond with anesthesiology journal editors via e-mail. He points out that e-mail is the most frequently used Internet application by physicians.

To illustrate this point, Dr. Ravindran says he recently presented a case of a patient with low hemoglobin to his anesthesiology discussion group. Within a few days, several members of the discussion group responded, explaining how they successfully administered anesthesia to patients with a similar condition.

For Dr. Ravindran, the biggest impact of the Internet will be to make research and other information available to physicians on-line months before they would receive the printed journals. As a result, new therapies can be implemented sooner and problems with existing procedures can be addressed immediately.

He acknowledges that the Internet can be confusing, but says it is becoming more and more organized, and clinical information is easier to find. Anesthesiology departments, including IU's, are establishing their own home pages on the Web, and more and more CME is being offered on the Internet.

"It's really a treasure house," says Dr. Ravindran. "If you don't get involved in the Internet, you are missing a lot. You can find information about a variety of clinical problems from all over the world. You can build contacts with other physicians, all from the comfort of your home. I'm convinced that in the future, we will have access to more useful information and we will spend less time looking for it than we do now."

How to get started

All you need to get on the Internet is a personal computer, a modem, some software and a telephone line. The cost of establishing and maintaining basic Internet access is relatively modest. Twenty dollars can buy you as many as 200 hours on-line per month.

Yes, the whole Internet thing can be intimidating, what with the initiated chortling about things like getting "flamed" for "spamming" on a listserv. But don't let the jargon put you off. Most people surfing the Internet are still pretty new at it themselves and don't mind helping novices. Besides, there are lots of resources (see "For more information" on page 15) to help you get started. For physicians, one of the best resources may be someone, perhaps even another physician, who's already taken the plunge.

"If a doctor wants to get started in computing," advises Dr. Judy, "find someone who's already relatively familiar and use them as your guide and local expert. Appeal to someone's intrinsic desire to be helpful or to show off or be an expert or power user, and then let them be helpful." ❑

Bob Carlson is a health care writer based in Indianapolis.

Indiana court enforces 'any willing provider'

Paul R. Black
Brian K. Peters
Indianapolis

Managed care. The variety of HMOs, PPOs, PSNs, IDNs and so on dominate the discussion of health care delivery in the '90s. Insurers, employers, provider groups and other interested parties are negotiating varying arrangements in hopes of putting together competitive and cost-effective networks. Providers are so aligning themselves because payers prefer to contract with networks that can provide a complete package of health services at competitive rates.

However, competition engenders provider exclusion. Network organizations use exclusion as a tool of network efficiency. Network managers assert that networks reduce costs and improve services by fostering competition between providers. They argue that network providers can reduce fees because limiting the panel of providers assures the panel access to a sufficient volume of patients to warrant the fee reduction. Further, many providers bargain for network participation to exclude their competitors from access to a particular payer.

Provider exclusion and 'any willing provider' laws

So, are there any limitations on the ability of networks to exclude a single provider or group of providers, or even another intermediary network of providers? The answer is a qualified yes. Policies limiting exclusion largely are rooted in state and federal antitrust laws, and in state "any willing provider" laws. However, the antitrust laws have not yet become a lightning rod for debate although they certainly have that potential. At least currently, the formation and organization of managed care networks are being analyzed by courts and enforcement agencies under antitrust laws based on what is referred to as the "rule of reason." This essentially means that any "reasonable" basis for the way in which a network is organized (and its exclusion of certain providers) may prevent it from being attacked as in violation of antitrust laws.

Indeed, at this writing, the Medicare Preservation Act of 1995, as passed by the House, provides that the conduct of a provider service network (or of any member of the network) in negotiating, making or performing a contract, including the establishment of a fee schedule and the development of a panel of physicians, for the purpose of providing health services under the terms of a Medicare Plus PSO contract, will be judged under the rule of reason and will not be deemed illegal per se.

As a result, the focus with respect to government regulation of provider exclusion from networks may rest, at least for the short term, with state "any willing provider" laws and similar legislation. These laws forbidding exclusion are further evolving as the result of ongoing lobbying efforts of the various interested parties at state and national levels. Around the country, many variants of the "any willing provider" laws are being legislatively proposed by providers. These include due process laws, which would require managed care networks to grant a hearing to a provider excluded from participation, and essential community service laws that would identify providers deemed "essential" to the community and require their inclusion in the network. Other legislation advancing notions of patient protection, mandated point of service and freedom of choice are being discussed.

Most of these laws are written against networks sponsored by insurance companies as opposed to networks sponsored by other providers. For example, Indiana's law was drafted as a statute regulating the insurance industry, and so applies only to insurance companies authorized to issue policies that provide reimbursement for expenses of health care services. Not surprisingly, the insurance industry refers to such laws as anti-managed care and has indicated it intends to lobby heavily against them at both the state and local levels. The Health Insurance Association of America has identified "any willing provider" laws as one of its primary legislative concerns for 1996.

On the other hand, the provider community, including the American Medical Association, has strongly supported "any willing provider" legislation and will likely continue to do so because such laws still benefit most providers. However, as provider-sponsored networks subject themselves to capitation and take on risk, their

ability to distinguish themselves from insurer-sponsored networks for purposes of this and other laws may lessen. Undoubtedly, for this reason, at this writing, the Medicare Preservation Act of 1995 as passed by the House contains provisions that would exempt provider-sponsored organizations (PSOs) from "any willing provider" laws as well as from state insurance and HMO regulations that might prevent a PSO from operating as contemplated by Congress. Under this Medicare reform legislation, a PSO includes a group of affiliated providers who are sufficiently clinically and financially integrated as to be able to assume full risk and to provide a complete minimum Medicare benefit package.

Networks may have other means of exemption from "any willing provider" laws. For example, a recent federal court decision from Texas declared on behalf of insurance-sponsored networks that the Federal Employment Retirement Income Security Act of 1974 (ERISA) preempted the application of a state "any willing provider" statute to the extent that the networks contracted with self-insured employers. Yet other interested groups, including last year's universal coverage proponents, are lobbying Congress to limit the effect of ERISA preemption on state laws so that states can regulate the health benefit plans of such self-insured employers.

All of this means that one of the more clearly defined battle lines over further development of managed care networks is the extent of a network's ability to exclude certain providers from participation. Accordingly, providers who are or who would be network participants should stay abreast of these legal developments, since their bargaining position ebbs and flows with them.

Recent Indiana development

In Indiana, one such significant new development involving Indiana's "any willing provider" law about which all Indiana providers should be aware occurred this summer. An Indiana trial court issued an injunction enforcing Indiana's "any willing provider" statute and requiring the Associated Insurance Companies, Inc. (Associated) and Anthem Benefit Services, Inc. (Anthem) to readmit a physician who previously had been terminated from preferred provider networks operated by Associated and Anthem.

This case arose from network agreements entered into between a physician and Associated and Anthem that gave the companies the right to terminate the physician from participation in the networks with or without cause. After a billing dispute arose between the companies and the physician, Associated and Anthem exercised their rights under the agreements to terminate the physician without cause. In response, the physician asked to rejoin the networks effective as of the date of the attempted termination, pursuant to the Indiana Preferred Provider Organization Act, Indiana Code 27-8-11-1 through 27-8-11-5, (particularly, the "any willing provider" statute, Indiana Code 27-8-11-3).

Indiana's "any willing provider" statute provides that before entering into a preferred provider agreement, an insurer must establish terms and conditions of participation in the network, and these terms and conditions may not discriminate unreasonably against or among providers. It further provides that any provider willing to meet the established terms and conditions must be allowed to enter into an agreement with the insurer. The statute covers hospitals, physicians, pharmacists, dentists, podiatrists, optometrists, osteopaths, chiropractors and health service providers in psychology.

The physician, whose practice depended significantly upon the referrals generated by the network agreements, represented that he was willing to meet the terms and conditions of the network contracts and formally asked to obtain

Indiana's any willing provider statute provides that before entering into a preferred provider agreement, an insurer must establish terms and conditions of participation in the network, and these terms and conditions may not discriminate unreasonably against or among providers.

copies of the terms and conditions. Associated and Anthem replied that the terms and conditions of their network agreements were proprietary and could not be disclosed, except that one of the terms and conditions (previously undisclosed to the provider) was that "an application of a provider may be rejected (when) ... the provider has been terminated by the network(s) within the previous 36 months."

Before the effective date of the termination, the physician brought suit against Associated and Anthem, alleging a violation of the "any willing provider" statute and asking for an injunction requiring immediate reinstatement to the networks. The physician argued that a 36-month waiting period was illegal since the contract permitted termination without cause. Together, the two provisions effectively nullified the "any willing provider" statute because they allowed the insurers to enter into agreements with any provider, and then terminate the provider without cause, thereby excluding the provider from network participation for at least three years. Associated and Anthem countered that the 36-month waiting period and the "without cause" termination provisions applied to all other physicians participating or applying to participate in the networks and therefore should be upheld.

The court agreed with the physician and concluded that Associated and Anthem's refusal to readmit the physician was a potential violation of the "any willing provider" statute. As a result, the court entered a preliminary injunction requiring Associated and Anthem to allow the physician to remain in its networks pending a final determination on the merits of the case.

Although they had the right to do so, Associated and Anthem did not appeal the preliminary injunction. What is not clear is whether they will seek to change the "any willing provider" statute, which was the basis for this decision, in the Indiana General Assembly.

This appears to be the first court decision anywhere in the United States enforcing "any willing provider" law against an insurer sponsored network. While some previous decisions in other states have held such laws effective, no other court has actually required an insurer to admit, or retain, a provider in its network.

The full impact of this decision remains to be seen, but for the time being it certainly gives providers in Indiana a strong argument that they cannot be excluded from managed care networks at the desire of the network. The combination of a network contract that gives the insurance company termination rights for no reason, together with terms and conditions of participation that prevent providers previously terminated from reapplying for any period of time, is contrary to Indiana's "any willing provider" law according to this court.

There are limitations to the decision and the "any willing provider" law. Indeed, Anthem, which acts essentially as an administrator of benefit plans, argued that it was not an insurance company and so was not subject to Indiana's "any willing provider" law. While the court has not yet ruled on this argument, this limitation probably means, for instance, that provider sponsored networks are not subject to Indiana's law so long as they are not organized and regulated as insurance companies providing reimbursement for services.

As health care delivery systems continue to develop and evolve at an ever-increasing rate, all that can be said for certain about "any willing provider" laws and their variants is that they will be the focus of debate over government regulation of the relationship between managed care networks and providers. Many providers view them as an essential source of protection from unilateral decision-making by the networks, and insurers and insurer-sponsored networks view them as inimical to their ability to establish cost-effective delivery systems. As a result of the "any willing provider" law and the willingness of an Indiana trial court to enforce it against insurance companies, providers appear to have the upper hand in Indiana, at least for now. ❑

The authors are attorneys with the law firm of McHale, Cook & Welch in Indianapolis, practicing in the area of health care law and litigation.

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Seven ways to avoid frivolous malpractice claims

John Muller
Indianapolis

As an attorney who represents plaintiffs in medical malpractice claims, I often hear valid complaints from my physician friends about "frivolous malpractice claims." Frivolous claims take up valuable time in non-productive meetings with attorneys, depositions, etc., and they complicate applications for hospital privileges and professional liability insurance. Even a favorable outcome does not compensate for the emotional turmoil and inconvenience that goes with litigation.

In a sense, American medicine is a victim of its own good press. Much frivolous litigation is attributable to what I call the "miracle or malpractice" syndrome. Patients read about astounding medical advances where limbs are reattached, organs are transplanted, heart vessels bypassed and cancers cured. The public ends up believing that doctors really can perform miracles, and, of course, patients want miracles. Anyone with a serious medical problem wants to believe that there is a safe and reliable treatment for the problem. That is only human nature. When a patient has a result that is less than a miracle, the patient sometimes concludes that it must have been malpractice.

Here are seven points to help physicians avoid frivolous malpractice claims:

1. Maintain good personal relationships with your patients.
There is no question that physicians who have good personal relationships with their patients have fewer overall claims and certainly fewer frivolous claims. Patients who like their physicians are less likely to sue them.

The changes in medicine though are making personal relationships with patients more difficult. With increased specialization and compartmentalization of medicine – not to mention the economic pressures – physicians see more patients, each for a shorter period of time. The physician has less time to develop the personal relationship that used to exist between doctor and patient. However, a few extra minutes with a patient, and a note in the chart about the patient's personal interests, can do wonders for a relationship and may, in the long run, be worth the time invested.

2. Be aware of the difficulty in communicating with patients.
Patients often have a very poor understanding of their medical condition and their treatment, even when the medical issues have been thoroughly explained by the physician.

Physician-patient conversations about medical procedures and risks are an especially difficult communication setting. Patients are usually nervous when talking to their doctor. They know the doctor is busy, and they suspect that he or she does not have time to deal with their questions. If their medical condition is serious, the patients are likely to be anxious, distracted and reluctant to ask questions. Often, they simply do not know what questions to ask. Furthermore, the patient is often hearing from the physician complicated, technical information that may involve complex risk analyses.

Given the circumstances, it is not surprising that many patients who have major procedures understand very little of their medical situation and the risks associated with them. If there is a bad outcome, this lack of understanding can lead to unwarranted malpractice claims. When talking to patients, be conscious of the difficulty that the patient may have in understanding what you are trying to communicate.

3. Give the patient information about the patient's condition and treatment.
If you routinely treat a particular condition or do a procedure, consider giving the patient written information about that condition or procedure. Many of the drug companies and appliance manufacturers have excellent pamphlets, clearly written in layman's terms, that give a good overview of particular conditions. In addition, there are commercial video tapes on various medical problems.

One company is developing an interactive CD-ROM to be used for informed consent. Using a personal computer, the ROM explains the medical procedure and has the patient answer questions that establish the patient's understanding of the procedure and the risks of the procedure. If these materials are not available on your procedures, consider writing your own short summary.

Patients want medical information and especially appreciate

material that they can take home and review. They can show it to their spouse or other family members and discuss it at length. The more the patient understands about his medical condition and treatment, the less the chances of an unwarranted claim.

4. Place the risk of a procedure where it belongs, with the patient. An important corollary to providing information about a patient's medical treatment is to make certain that the patient understands the risks associated with the treatment. It is the patient who has the medical condition, and the risks associated with that condition should be with the patient, not the doctor. It is important that the patient understands and accepts those risks.

This may run counter to your natural instinct. When confronted with a nervous and apprehensive patient, the inclination is to reassure the patient. "Don't worry. I do this procedure all the time, and there are rarely any complications. Everything is going to be fine."

This will be reassuring, but it feeds the patient's belief that there are no risks with the procedure, and the patient may end up with unrealistic expectations. If the results of the procedure are favorable, this is no problem. However, if there is an unfavorable outcome, the patient is likely to conclude that the unfavorable outcome was a result of substandard treatment.

It is important, but often difficult, to make patients understand and accept the risks inherent in their condition and treatment.

5. Respond promptly to requests for information and medical records. It is important to respond promptly and fully to requests for medical records. There is a surprising level of suspicion, if not outright paranoia, when a patient is considering malpractice litigation. Whether it is warranted or not, the public is generally cynical about the integrity of medical records in the context of malpractice litigation. Patients may view any hesitation or equivocation about turning over medical records as confirmation that an underlying problem is being concealed.

The same considerations apply to changes in the records. Patients and juries view any attempt to alter records as evidence that there was a problem in the original treatment. In reviewing a record, if you see that a correction needs to be made, put one line through the old notation, being careful not to obliterate it. Write the correction so that it can be clearly identified as a correction. Then, initial and date the correction. By doing this, you eliminate any suspicion that an attempt was made to alter the records.

Withholding records and alterations in records are red flags that feed a patient's suspicions and can lead to unnecessary claims.

6. Chart thoroughly and legibly. When a plaintiff's attorney reviews a medical malpractice claim, the attorney has only the medical records and the patient's story to evaluate. The patient often knows little or nothing about the situation. If the records are incomplete or illegible, the plaintiff's attorney will have to evaluate the claim with incomplete information. The attorney has no way of supplementing the information in the chart. The attorney cannot, for instance, call a physician and ask what line three of the progress note says.

The only way that the attorney can get that information is to put the claim on file, take the doctor's deposition and ask the doctor to read that particular line. The illegible note may be information that you want the plaintiff's attorney to have before he files a claim.

Consider charting not only the diagnosis and treatment but any diagnoses or treatments that were considered and rejected. Judgment calls on medical issues are almost always decided in favor of the physician, even when in hindsight, they were not correct. So, a notation that a particular diagnosis or a particular treatment was considered and rejected, with the medical reason, will eliminate a claim that a diagnosis or treatment was not considered.

Incomplete or illegible charting may leave questions unanswered that can only be answered in litigation. It is better to write it clearly in the chart than explain it in a deposition.

7. Consider giving the plaintiff's attorney the information that establishes the claim is frivolous. If you do get named in a frivolous claim, consider sharing with the plaintiff's attorney the information necessary to convince the plaintiff's attorney that the claim is without merit. Most frivolous claims are filed because the plaintiff's attorney does not have accurate or complete information.

Keep in mind that the attorney had only the chart to review when

he or she evaluated the claim. The attorney may or may not have been able to find a competent medical consultant to give reliable information on the medical issues. Sometimes, a simple affidavit providing the attorney with additional information can resolve the issue quickly.

You and the plaintiff's attorney have a common interest in seeing that frivolous litigation is resolved as quickly and efficiently as possible. The plaintiff's attorney is working on a contingent fee basis. The attorney is not going to be compensated for a frivolous claim. When a non-meritorious claim has been filed, the plaintiff's attorney's interest is in documenting that it is not a legitimate claim and closing the file with as little investment of time as possible. That is in your interest as well. Consider helping the attorney do that by giving the information that he or she needs.

When a lawsuit is filed, the lines of communication become formalized and difficult. There is a tendency, especially among older defense attorneys, not to give the opponent any information about the case. However, there are some things that you want your opponent to know about a case. To make the opponent work for that information is counterproductive.

There are two important caveats to this advice which dictate that this should be done only in consultation with an experienced malpractice defense attorney.

First, what you consider to be a frivolous claim may not be viewed by others as a frivolous claim. The defense attorney needs to evaluate the claim to see if in his or her opinion it is frivolous. The defense attorney also needs to evaluate the information that you intend to give the plaintiff's attorney to decide whether it is likely to convince the plaintiff's attorney that the claim should be dismissed.

Secondly, not all plaintiffs' attorneys will act responsibly on the information and dismiss the claim. Defense attorneys generally know those plaintiffs' attorneys who have the experience and inclination to evaluate information and act appropriately on it. That decision needs to be made by an experienced malpractice defense attorney.

In general, the more information given to a plaintiff's attorney about a frivolous claim, the more likely it is to be resolved quickly and efficiently.

Conclusion

The one thread that runs through all of these pointers is communication. Frivolous medical malpractice claims are often a result of miscommunication. ❑

The author is an attorney with Miller Muller Mendelson & Kennedy in Indianapolis.

Utilizing generation skipping techniques

Joel M. Blau, CFP
AMA Investment Advisers

The generation skipping transfer tax (GSST) is a complicated and sometimes misunderstood area of estate tax planning.

Many physicians pass large amounts of wealth to their children via gifts and other estate planning techniques but would also like to pass extra wealth to their grandchildren or great grandchildren. In many circumstances, their children may already be wealthy or financially secure as a result of their own individual accomplishments. These children may not want to have additional wealth passed on to them, which would cause increased taxation in their own estates. An alternative is to pass wealth to the grandchildren without incurring estate taxation in their children's estate. This strategy falls under the impact of the GSST. The GSST imposes a flat tax of 55%, which is in addition to any gift or estate tax on every generation skipping transfer. This applies to transfers to a beneficiary two or more generations below the donor, such as grandchildren and great grandchildren.

Every taxpayer is allowed to transfer $1 million free of the GSST. The exemption is most effectively used to transfer property today, and thus, remove all future appreciation from the GSST by using a "direct skip." A direct skip is an outright gift or bequest to third generation family members (skip persons) or a gift in trust, if all trust beneficiaries are skip persons. A lifetime direct skip receives the most favorable tax treatment for the donee since it is tax "exclusive," meaning the donor is responsible for paying any GSST. In addition, a lifetime direct skip transfers all future appreciation to the skip person and removes it from further generation skipping taxation. By transferring rapidly appreciating property, fully sheltered by allocating the GSST exemption, the impact of the tax can be greatly reduced or even eliminated and the value of the gift is enhanced.

In addition to the amount sheltered by the GSST exemption, other transfers are available that would not be subject to the tax. The other major exclusions available are gifts that qualify for the $10,000 annual exclusion, direct payment of tuition to educational institutions and direct payment of medical expenses. For instance, a grandparent can pay for a grandchild's college education free of gift tax and GSST by making payments directly to the school rather than gifting the funds to the grandchild.

Of course, the most effective planning strategy for generation skipping is to create a transfer that will be entirely exempt from GSST. This is accomplished by limiting transfers to an amount that can be sheltered by the GSST exemption. The leverage gained by allocating the GSST exemption to lifetime direct skips can be substantially increased by establishing an irrevocable trust funded with life insurance. At little or no tax cost, large sums of wealth can be transferred to grandchildren and great grandchildren through the leverage created by the life insurance death benefit owned by the trust.

When carefully structured, a leveraged generation skipping trust can be a very powerful tool for passing wealth to future generations. Your estate tax attorney can help you determine the effectiveness of this strategy for your own personal situation. ❑

The author welcomes readers' questions. He can be reached at 1-800-262-3863.

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1995 ISMA convention photo highlights

William E. Cooper, M.D., Columbus, ISMA immediate past president, right, congratulates Jerome Melchior, M.D., Vincennes, upon his installation as ISMA president for 1995-96.

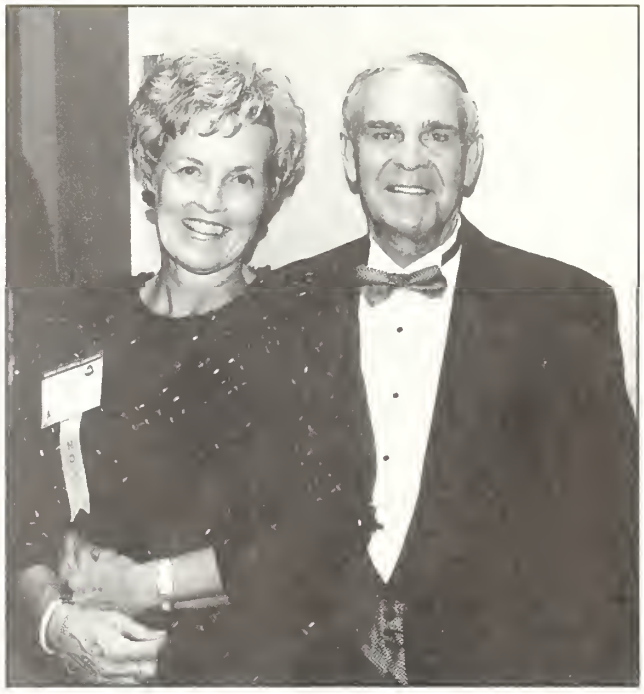
Jerome Melchior, M.D., and his wife, Martha, are shown at Presidents' Night events. Dr. Melchior, a Vincennes urologist, was installed as president during the convention.

Valerie Gates, Valparaiso, the ISMA Alliance president, and her husband, Greg Gates, M.D., were honored at Presidents' Night.

Members of Reference Committee 3, which heard legislative issues, are, from left, Steven Isenberg, M.D., Indianapolis; William Mohr, M.D., Kokomo; Promila Paul, M.D., Munster; Dung Nguyen, M.D., Indianapolis; and William Pond, M.D., Fort Wayne.

Fred Barnes, a nationally known political commentator, speaks at the annual IMPAC luncheon. He is executive director of *The Standard*, a weekly conservative magazine that he founded and began publishing in September. He was formerly senior editor at *The New Republic*.

John Knote, M.D., a Lafayette radiologist, at microphone, is surprised with a collage of mementoes from his campaign and subsequent election as AMA vice speaker. The presentation was made during the first session of the House of Delegates. Jerome Melchior, M.D., a Vincennes urologist, is at right.



Alfred Cox, M.D., ISMA president-elect, and his wife, Ellaine, were honored at an afterglow hosted by the St. Joseph County Medical Society and the 13th District Medical Society. Dr. Cox is a family physician from South Bend.

William E. Cooper, M.D., and his wife, Nancy, greet Freg Haggerty, M.D., a Greencastle family physician, and his guest, Nancy Beachkofsky, at Presidents' Night.

The Association of Indiana Directors of Medical Education presented plaques to, from left, Lindley H. Wagner, M.D., Lafayette, in appreciation of his service as president, and Donald T. Olson, M.D., South Bend; Edward F. Steinmetz, M.D., Indianapolis; and Larry Lawson, M.D., Muncie, in recognition of their work as the founding members of AIDME.

Awaiting the opening of the first session of the House of Delegates are brothers Donald McCallum, M.D., left, a Franklin urologist, and James McCallum, M.D., an Indianapolis ophthalmologist.

Sen. Robert Garton, R-Columbus, president pro tempore of the Indiana Senate, speaks at the Key Contact seminar that was part of the semi-annual meeting of the Indiana Roentgen Society.

Members of the panel discussion on "The Changing Environment of Health Care Delivery" were, seated from left, Scott Weingarten, M.D., director of health services research at Cedars Sinai Medical Center in Los Angeles; Ben Park, M.D., Indianapolis, founder and president of the American Health Network; Gary Erskine, executive director of the Arnett Clinic in Lafayette; Douglas D. French, president and CEO of St. Vincent Hospital in Indianapolis; and Steven F. Isenberg, M.D., an Indianapolis otolaryngologist and founder and CEO of Project Solo, a national information database formed for independent physicians.

Robert Stevenson, M.D., a New Castle internist, stops to talk with Barbara Hollingsworth, center, and Kimberly Harper at the Indiana Medical Access and Communication System (IMACS) booth in the exhibit hall.

The Bloomington contingent at Presidents' Night included, from left, Robert Wrenn, M.D., an obstetrician/gynecologist, and his wife, Ann, the AMA Alliance secretary; and Judy Lawrence with her husband, Larry Lawrence, M.D., a psychiatrist.

The dance floor was a lively place at Presidents' Night as guests kicked up their heels to the music of Off Center.

Susan Amos, M.D., and her father, Paul Siebenmorgen, M.D., an ISMA past president, served as delegates. Both are family physicians from Terre Haute.

1995 ISMA convention coverage

Call to order, miscellaneous business

The Indiana State Medical Association House of Delegates convened its 146th annual convention at 9 a.m., EST, Friday, Oct. 20, 1995, at the Radisson Hotel in Indianapolis. The final session of the House of Delegates convened at 9 a.m., EST, Sunday, Oct. 22, 1995.

Presiding at both sessions was Peter Winters, M.D., Indianapolis, speaker, assisted by John Thomas, M.D., Fort Wayne, vice speaker. J. Vannoy Faris, M.D., Indianapolis, served as parliamentarian. Allen Rumble, pastor of the Zionsville United Methodist Church, presented the invocation.

Approval of minutes

The proceedings of the 145th annual meeting of the House of Delegates, Indiana State Medical Association, conducted Oct. 21-23, 1994, at the Westin Hotel, Indianapolis, and published in the January/February 1995 issue of *Indiana Medicine*, were approved.

Addresses, reports

The addresses of the president, president-elect and president of the ISMA Alliance, all referred to Reference Committee 1, were filed with commendation.

All reports (printed in the September/October 1995 issue of *Indiana Medicine*) were filed, with the exception of the treasurer's report, which is referred for audit.

Election of officers

Jerome Melchior, M.D., Vincennes, president-elect, succeeded to the office of the president. Alfred Cox, M.D., South Bend, was elected president-elect. Other elections included:

Treasurer – Timothy Brown, M.D., Crawfordsville

Assistant treasurer – Frank Sturdevant, M.D., Valparaiso

Speaker of the house – Peter Winters, M.D., Indianapolis

Vice speaker of the house – Stephen Tharp, M.D., Frankfort

Chairman, board of trustees – Bernard Emkes, M.D., Indianapolis

At large members, executive committee – Barney Maynard, M.D., Evansville, and Tom Brubaker, M.D., Griffith

Election of delegates, alternate delegates to the AMA

The following were elected to two-year terms as delegates and alternates to the American Medical Association (terms expire Dec. 31, 1997):

Delegates:
C. Dyke Egnatz, M.D., Schererville
John MacDougall, M.D., Indianapolis
Michael Mellinger, M.D., LaGrange

George Rawls, M.D., Indianapolis, was elected to a one-year term as a delegate. This additional delegate seat was granted by the AMA due to the election of John Knote, M.D., of Indiana, a delegate, as AMA vice speaker. This term expires Dec. 31, 1996.

Alternates:
William Cooper, M.D., Columbus
Paula Hall, M.D., Mooresville
Barney Maynard, M.D., Evansville

Holdover AMA delegates and alternate delegates (terms expire Dec. 31, 1996) are:

Delegates:
William Beeson, M.D., Indianapolis
Shirley Khalouf, M.D., Marion
John Knote, M.D., Lafayette

Alternates:
Alfred Cox, M.D., South Bend
Max Hoffmann, M.D., Covington
Jerome Melchior, M.D., Vincennes

Trustees, 1995-1996
District 1 – Barney Maynard, M.D., Evansville
District 2 – Fred Ridge Jr., M.D., Linton
District 3 – John Seward, M.D., Bedford
District 4 – Arthur Jay, M.D., Lawrenceburg
District 5 – Fred Haggerty, M.D., Greencastle
District 6 – Ray Haas, M.D., Greenfield
District 7 – Paula Hall, M.D., Mooresville
District 7 – John Records, M.D., Franklin
District 7 – Bernard Emkes, M.D., Indianapolis
District 8 – John Osborne, M.D., Muncie
District 9 – Gerald Wehr, M.D., Lafayette
District 10 – Thomas Brubaker, M.D., Griffith
District 11 – Regino Urgena, M.D., Marion
District 12 – Joseph Mantheiy, M.D., Liberty Center
District 13 – Richard Houck, M.D., Michigan City
Resident Medical Society – Ruchir Sehra, M.D., Indianapolis

Medical Student Society – Madeline Eversoll, Indianapolis

Alternate trustees, 1995-1996:
District 1 – John Berry, M.D., Evansville
District 2 – Ralph Stewart, M.D., Vincennes
District 3 – Kevin Burke, M.D., Jeffersonville
District 4 – Lawrence Bailey, M.D., Aurora
District 5 – Fred Drake, M.D., Terre Haute
District 6 – Howard Deitsch, M.D., Richmond
District 7 – Frank Johnson, M.D., Indianapolis
District 7 – Craig Moorman, M.D,. Franklin
District 7 – Girdhar Ahuja, M.D., Indianapolis
District 8 – Susan Pyle, M.D., Union City
District 9 – Michael Stewart, M.D., Crawfordsville
District 10 – John Swarner Jr., M.D., Valparaiso
District 11 – William Mohr, M.D., Kokomo
District 12 – Scott Wagner, M.D., Fort Wayne
District 13 – David Hornback, M.D., South Bend
Resident Medical Society – Dung Nguyen, M.D., Indianapolis
Medical Student Society – Erin Baker, Indianapolis

1996 meeting
The 1996 ISMA annual meeting will be Oct. 18-20 at the Westin Hotel, Indianapolis. ❑

In memoriam

The ISMA pays tribute to its members who have died since the 1994 session:

Robert Acher, M.D., Greensburg
Virgil Angel, M.D., Highland
John Armstead, M.D., Indianapolis
Charles Austin, M.D., Anderson
Norman Beaver, M.D., West Lafayette
Robert Beck, M.D., Newburgh
Arthur Blazey, M.D., Santa Claus
Robert Bolin, M.D., Lafayette
Richard Buckingham, M.D., Bloomington
Donald Buehner, M.D., Evansville
James Burk, M.D., Decatur
Lee Cattell Jr., M.D., Louisville, Ky.
Rodney Caudill, M.D., Yorktown
Paul Chivington Jr., M.D., Carmel
Frank Coble, M.D., Richmond
James Conklin, M.D., Terre Haute
John Crist, M.D., Evansville
Gail Eldridge, M.D., Indianapolis
Lee Foster, M.D., Carmel
Russell Havens, M.D., Fort Wayne
Ramon Henderson, M.D., Muncie
Deward Houser, M.D., South Bend
William Howard, M.D., Nashville
Arnold Johnson, M.D., Gary
Forrest Keeling, M.D., Columbus
David Koransky, M.D., Highland
Arthur Larson, M.D., Elkhart
Iris Legaspi, M.D., Munster
Ralph Leser, M.D., Indianapolis
Andreas Lutz, M.D., Highland
Carl Martz, M.D., Punta Gorda, Fla.
Howard Marvel, M.D., West Lafayette
Chester McClure, M.D., Madison
Ralph McQuiston, M.D., Indianapolis
Dennis Megenhardt, M.D., Indianapolis
Donald Miller, M.D., Cedar Lake
Antonin Montecillo, M.D., Clinton
William Mount, M.D., Battle Ground
Donal O'Sullivan, M.D., Evansville
Douglas Offutt, M.D., Newburgh
Margaret Owen, M.D., Bloomington
Renu Pandya, M.D., Lafayette
Harold Petijean, M.D., Haubstadt
Frank Peyton, M.D., West Lafayette
Richard Pryor, M.D., Indianapolis
Thomas Redlin, M.D., Elkhart
John Robb, M.D., Indianapolis
Bernard Rosenak, M.D., Indianapolis
Byron Rust, M.D., Sarasota, Fla.
Eugene Schmidt, M.D., Fort Wayne
Arthur Scudder, M.D., Brownsburg
William Sharp, M.D., Alexandria
Carl Stallman, M.D., Kendallville
Byron Steger, M.D., San Antonio, Texas
Ronald Swaeby, M.D., Switz City
Everett Taylor, M.D., Upland
Ian Templeton, M.D., St. Petersburg, Fla.
Harry Tunnell III, M.D., Fort Wayne
Thomas Tyrrell, M.D., Munster
Edmund VanBuskirk, M.D., Lafayette
James Warriner, M.D., Indianapolis
Julia Wixted, M.D., Phoenix, Ariz.
Elmer Zweig, M.D., Fort Wayne ❑

Jerome Melchior, M.D., installed as ISMA president

Jerome Melchior, M.D., a Vincennes urologist, was installed as president of the ISMA Oct. 22 during its 146th annual meeting.

During his speech to the House of Delegates, Dr. Melchior said physicians cannot rest on past legislative achievements and that the core of ISMA's legislative stretegy is physician cohesiveness. He encouraged ISMA members to bring new physicians into organized medicine.

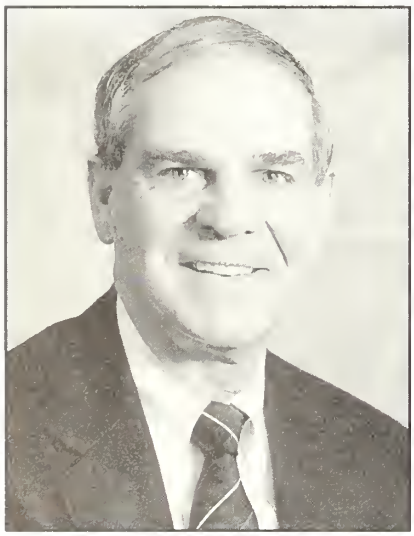
"Commitment is infectious. The physician with a purpose and a plan to be the patient's advocate is treated with admiration. These are the physicians that we must push into involvement and then on to commitment," he said.

During his one-year term as president, Dr. Melchior will chair the ISMA executive committee. A 1967 graduate of the University of Kansas School of Medicine, Dr. Melchior is certified by the American Board of Urology and is a fellow of the American College of Surgeons and a member of the American Urology Association. He is a staff member at Good Samaritan Hospital in Vincennes, where he has been president of the medical staff, chairman of the hospital utilization committee and chairman of surgery service.

He has served as ISMA trustee and alternate trustee of the Second District. ❑

Dr. Melchior

Alfred C. Cox, M.D., named ISMA president-elect



Dr. Cox

Alfred C. Cox, M.D., a family practice physician from South Bend, was named president-elect of the ISMA during its annual convention.

A 1962 graduate of the Indiana University School of Medicine, Dr. Cox has been in private practice for 32 years and is a past president of the Memorial Hospital medical staff in South Bend. He served as associate medical director of Key Health Plan from 1985 to 1992.

He is a member of the Indiana Academy of Family Physicians and the American Academy of Family Physicians.

Dr. Cox has served on the ISMA board of trustees since 1989. ❑

Address of the president William E. Cooper, M.D.

I want to thank you for the opportunity to serve as your president this year. I do appreciate all of your support. But there is one person in the room today I want to thank, not only for my being in the medical association, but for my life in medicine. That's Dr. Joe Black.

As many of you probably know, Joe practices in Seymour, where I grew up. As many of you may not know, Joe's the primary reason I'm here today and have enjoyed a life in medicine. Joe was our family physician. Like many young kids growing up, I didn't have a clue of what I wanted to do with my life. My first job was as a student typist in the school office. I guess today that's what they call a work study program.

One day I looked up from my typing and there was Dr. Joe. He said, "Billy, have you decided where you are going to go to college?" I hadn't even decided if I was going to college.

But he commanded so much authority and respect I thought "Maybe I better go to college." And when I got there, I looked around and found that medicine was really what intrigued me.

As many of you know, Dr. Joe was president of the Indiana State Medical Association and served during one of medicine's pivotal years – 1965, the year Medicare came into being. Through the leadership of colleagues like Dr. Joe, the state association helped doctors adjust to that upheaval . . . that changing climate.

It was a climate that threatened to destroy the very heart of medicine . . .the physician-patient relationship.

Suddenly things were being done to us . . . not by us, and certainly not for us. Sound familiar? Sound a lot like today?

I have been struck more than once by the parallels between Dr. Joe's year and my year. Again things are being done to us, not by us, and certainly not for us. And again, I've tried to draw on Dr. Joe for my inspiration . . . as I worked with staff, with leadership and with membership. Just as doctors – being the bright, capable people they are – coped back then, we're going to cope today.

That's been my mission this year as your president. In the legislative arena alone, ISMA was instrumental in protecting the practice of medicine and the patients you serve. Because of the efforts of the ISMA, Indiana doctors in managed care plans can now use our best medical judgment on behalf of our patients – without fear of reprisals from the plan.

Because of the efforts of the ISMA, insurance companies cannot "cherry pick." For years they've cherry picked patients and when they tried to pick doctors, we stopped them.

Because of the efforts of the ISMA, we've stopped kneejerk regulation and kneejerk legislation – with the establishment of the Medicaid Clinical Advisory Committee.

The Good Sam law is now also a good sense law. It now covers not only accidents, but emergencies.

Because of the efforts of the ISMA, the General Assembly enacted HB 1623. The office of attorney general must notify physicians before the medical licensing board can suspend their license.

Dr. Cooper

And now retired physicians who want to volunteer their time in clinics can do so without having to assume the burden of paying for liability insurance. Physicians who want to serve . . . and patients who need their services . . . we brought them together.

And I know it didn't happen on my watch, but I would be remiss if I didn't remind you that this year is the 20th anniversary of INCAP, the Indiana Compensation Act for Patients.

While other states have struggled with liability reform, Indiana physicians have enjoyed the freedom of looking at our patients as our friends, not our potential foes.

And it's not just in the legislative arena that we've focused our efforts. We've been active in public law and in public health. Our partners in medicine, the Alliance,

have not only heightened our awareness of the problem of domestic violence, but have also helped us work toward providing programs and solutions. Whether sponsoring women and family shelters in our home towns . . . or working with the Indiana Coalition Against Domestic Violence . . . or talking with legislators on Medicine Day . . . or raising money to assist IU Medical students . . . The alliance is there.

And in tending to the health of the public, we've not neglected the health of our association. Many state presidents I've talked with this year tell me budgets are tight; they're struggling. I'm proud to report to you we are on a solid financial footing. Membership in the association is up. Seven thousand nine hundred strong. More than eight out of 10 doctors in our state support our association. I know we're not happy with 85% – we Hoosiers want 100%. But that's a record many states are looking at with envy.

And we've made our presence felt in another arena, too. We have the opportunity of seeking the presidency of the AMA. John Knote! Now, John's a great guy. A good friend of mine and a hard worker. But he'd be the first to admit that he didn't get elected by himself.

Like me and other leaders in Indiana medicine, he knows we doctors don't make it happen alone. We've had outstanding leadership and outstanding staff helping us this year. From John MacDougall who was Dr. Knote's campaign manager to Rick King who heads up the staff. To Susan Grant, Mike Abrams, Adele Lash, Jennifer Floyd and Ron Dyer, right on through to Debbie Kelly, who answers our 800 number. We have a staff that I know all our members appreciate and are proud of. Please join me in showing our appreciation.

You know, I've been in six or seven states on behalf of ISMA. I have to tell you it was always a pleasure to come home to our association and staff. There are some other people that I owe a debt of gratitude. I want them to stand as I recognize them, but I want you to hold your applause until the end. First, the Bartholomew-Brown County Medical Society, led by President Helen Kinsey; the Brown-Bartholomew County Medical Alliance, led by President Lisa Brueggeman and the Fourth District Medical trustee, Art Jay.

And, of course, my wife, Nancy.

Please join me in thanking them.

I began this morning on a very personal note. The story of how my mentor, Joe Black, helped me to a life in medicine. He's been my teacher, my mentor, my friend. I want to close today with a challenge to each of you here.
I told you how Joe rescued me from a career as a typist nearly 40 years ago. If he'd rescued me today, it wouldn't be from typing. I'd be flipping burgers at McDonald's, stocking shelves at K Mart or sacking groceries at Marsh.

My challenge to you is to be the Joe Black of your generation . . . your community.

Find that burger flipper who belongs in family practice . . . that stocker at K Mart who belongs in clinical pathology . . . that grocery sacker who belongs in general surgery and guide them as Joe guided me . . . into one of the most wonderful . . . the most challenging . . . the most fulfilling professions that I know.

Thank you. ❑

Address of the president-elect, Jerome Melchior, M.D.

Mr. Speaker, officers, trustees, delegates, alliance members and guests:

Over the years, I understand my predecessors, since 1849, labored over the creation of an ISMA presidential speech. After completing my task, I promise not to take 146 years or 146 minutes and hopefully less than 14.6 minutes to deliver my address today.

Before I begin, however, I must paraphrase Dr. Bob McAfee, immediate past president of the AMA, and tell you that, as your humble servant, never in my wildest dreams did I imagine I would be president of the Indiana State Medical Association, but then again my wildest dreams seldom have anything to do with the ISMA!

As Dr. Cooper reminded us, physicians in 1965 faced the largest social medical transition ever in the United States, Medicare and Medicaid. Today, ISMA members are once again confronted with a massive realignment of health care delivery.

We cannot rest on our past legislative achievements. The challenges to ISMA membership are numerous. What is the single thread that runs through all of the challenges facing us? What is the core of our strategy? Physician cohesiveness and collegiality! We need to join together to produce reasoned solutions that represent the dual goals of patient satisfaction and physician clinical autonomy.

Here's how the ISMA is working to create a more cohesive membership.

The ISMA has embarked on an aggressive member education program. Your association has taken the lead role in assisting physicians in understanding the opportunities and challenges in the new medical environment. Our landmark Physician Hospital Organization study, through a joint venture with the AMA, Michigan State Medical Society, and the Illinois State Medical Society, has assisted PHO development all over the state.

As a result of the initial study and feedback from physicians, the ISMA has just published a follow-up Physician Organization study. Additionally, the ISMA is currently involved in a feasibility study with the Illinois and Ohio state medical associations on the creation of a Management Services Organization. The MSO is the logical outgrowth of our Second Opinion Program that provides a listing of experts for physicians to use in the creation of new practice entities.

At the request of this House, the ISMA has completed an up-to-date comparison of managed care contracts. You'll find that report on your tables today.

I believe ISMA also must become involved in the further education of its members regarding physician data and profiling. To compete in the 21st century, all physicians need to have access to clinical data . . . data that are peer reviewed locally and compared on a regional, state and national basis. Physician practice behavior can be normalized if we, not the insurance industry, have input into what is the standard of care. A proposal is before this House to accomplish data collection. It deserves your careful and reasoned consideration.

Dr. Melchior

The ISMA is concerned about our ability to communicate with our members. I believe it is very difficult to build cohesion without effective communication. Therefore, we are conducting a top to bottom review of our efforts. ISMA is committing additional resources to use the tools of the 21st century . . . everything from blast faxes to the Internet . . . on your behalf. I am committed to maintaining the ISMA's excellent record of achievements as an organization focused upon physician representation and advocacy.

As you know, Congress is in the process of reforming Medicare and Medicaid on an unprecedented scale. I am hopeful you have read the reports about the AMA's success in transforming the

Medicare program. In short, it appears the House and Senate proposals address concerns of Indiana physicians. The federation of medicine – the AMA, ISMA, county societies, specialty societies and the alliance have successfully lobbied to increase the Medicare single conversion factor from $34.60 to $35.42. Other important sweeteners include:

1. Reform of Stark I/II
2. Exempting doctors' offices from CLIA
3. Limited anti-trust relief
4. A medical savings account option
5. Liability reform including limits of $250,000 on non-economic damages; and
6. Reform of the fraud and abuse statute.

As for Medicaid, one can assume it's a "done deal" that Medicaid will come to Indiana in a block grant form. According to some experts, the state can expect at least an 18-20% reduction in federal dollars and probably more. This reduction must not be made at the expense of those most in need within Medicaid – women and children.

Additionally, we are fearful that the cuts could result in reduced access to physicians. In anticipation of block grants, the ISMA executive committee is recommending to the board, in its budget, the addition of a reimbursement expert and policy analyst.

When we talk about advocacy, we cannot forget our partners in the alliance. To the alliance leaders and members here today, we are indebted for your efforts. We particularly appreciate your participation in Medicine Day at the Indiana General Assembly.

I would be remiss if I did not mention INCAP. As you know, INCAP, the Indiana Compensation Act for Patients, is the national standard for tort reform in the U.S. Unfortunately, the act is not without its critics, particularly the plaintiff trial lawyers and some members of the fourth estate. While the nation is moving in the direction we took 20 years ago, the judiciary in Indiana is slowly beginning its assault on INCAP. Several recent decisions are disturbing the foundation of the act.

The ISMA has begun a study of the act and the Patients Compensation Fund to obtain a clear understanding on which direction to proceed in strengthening INCAP. This year we published an updated white paper of INCAP. The board of trustees will closely monitor the situation, and I am sure will act in the best interest of the patients and physicians.

I've talked about cohesiveness. There's one more component . . . you! I challenge all physicians to show your commitment! Next meeting, bring a new member, one that you have helped move along the spectrum from physician to member, to involved, to committed.

It would be well if this newly committed physician was:

1. 10 years younger.
2. A different gender, race or country of origin.

Commitment is infectious. The physician with a purpose and a plan to be the patient's advocate is treated with admiration. These are the physicians that we must push into involvement and then on to commitment.

I wish to also comment on an observation made many years ago at this meeting. Your leadership are always on an elevated platform, and one could get the mistaken idea that the power actually resides here on this platform. This is definitely incorrect. We all need to remember that you, the House of Delegates, make the policy. We simply implement your decision. You decree. We agree.

As president, it will be my job to see that this occurs. If throughout the year you feel it does not, call me. I will promise to listen to your concerns, to explain our position and hopefully come to a harmonious solution.

Lastly, I'm going to quit before I end up like the medieval knight who returned home to his castle in very poor shape. He was bruised and battered. His armor was dented in a dozen places and he was practically falling off his horse. When the king came out to greet him, he asked the knight what on earth had happened to him. The knight said, "My lord, I merely went out to talk to your enemies in the West." The king said, "I don't have any enemies in the West." The knight said, "Well, now you do." I'm going to sit down before I make any more enemies. ❑

Address of the ISMA Alliance president, Valerie Gates

As ISMA Alliance president, I am here to bring you an update on what your Alliance has promoted this past year.

The alliance is an organization aligned with similar goals and objectives as the Indiana State Medical Association. Our membership consists primarily of physicians' spouses though we do have some physician members. The alliance has 24 organized counties. We also have a members-at-large category for those who live in unorganized areas. One of our state goals is to keep our members informed on the current issues affecting the practice of medicine.

We have worked to bring legislative awareness to each organized county by hosting legislative internships, forums and workshops. This past spring the alliance instituted a mini-legislative forum at the Capitol. A group of alliance members spent the day with a legislator from their area observing how the state legislature operates. Hopefully, this program can be expanded to include all counties instead of just the three we used as a pilot program. The alliance also actively participated in the Medicine Day ISMA function at the Capitol. We had the AMA-Alliance legislative chair address our full board meeting held in the afternoon of Medicine Day on the hows and whys of developing a good relationship with your legislators.

We are aware, as spouses of physicians, that your stresses very easily become our family stresses. In dealing with the intrusion of business and government into the way in which you practice medicine, these stresses sometimes seem insurmountable. Coping skills and warning signs of stress are topics which the alliance has covered and will continue to cover in our programs and workshops. We have, in fact, a two hour workshop planned for this afternoon with Dr. Clifford Kuhn, who will give us some insight on the light and dark sides of life.

The Alliance has had a productive year and encourages all of your spouses who are not members to join their county, state and national alliance as federated members. The AMA Alliance holds leadership training workshops in Chicago twice each year for county alliance president-elects. This is a tremendous opportunity for gaining additional information on current health care topics. The number of participants each state can send is determined by the number of AMA-A members in that state.

Valerie Gates

Please come to the alliance hospitality suite and view the displays which show the various activities each county has done on the behalf of medicine to help promote a positive public image in each local community. I would like to introduce you to those county alliance presidents who are here today. To help recognize them, they each are wearing a silk corsage. Please join me in acknowledging the dedicated work they do on your behalf.

Thank you for your time and attention. ⌟

Roland Chamblee, M.D., receives community service award

Roland W. Chamblee Sr., M.D., received the 1995 Physician Community Service Award from the ISMA and Wyeth-Ayerst Pharmaceuticals.

He was honored for his work at the South Bend Chapin Street Health Center, which serves the needy who might otherwise not receive medical care. Dr. Chamblee has served on the clinic's advisory board since 1986 and became the medical director in 1991. The center was one of the "Points of Light" initiative recognized by President George Bush in 1991.

He explains the clinic's philosophy: "People come here because they hurt. Physically, emotionally and even spiritually, they're down. It is immaterial to us whether a patient is white or black, young or old, suffering from nasal congestion or a confirmed case of AIDS. We treat them one at a time with dignity due everyone."

Dr. Chamblee

Dr. Chamblee has been a member of the family practice and medical staffs at Memorial Hospital and St. Joseph's Medical Center in South Bend since 1954.

He has been honored for his work by several organizations. He twice received the Urban League Meritorious Service Award and in 1965 was presented the Action Award as State Knight of the Year by the Knights of Columbus. He has also received the Brotherhood Award of the National Conference of Christians and Jews and the Helping Hand Award from Hospice of St. Joseph County. Dr. Chamblee was appointed a member of the Equestrian Order of the Knights of St. Gregory the Great by Pope John Paul VI. The award was established in 1830 in recognition of personal character, reputation and notable accomplishments. He was named Citizen of the Year, Meritorious, by the African Methodist Episcopal Church.

From 1972 to 1973 he was the physician-in-charge of the Naggalama Hospital Nakifuma in Uganda, East Africa. ❑

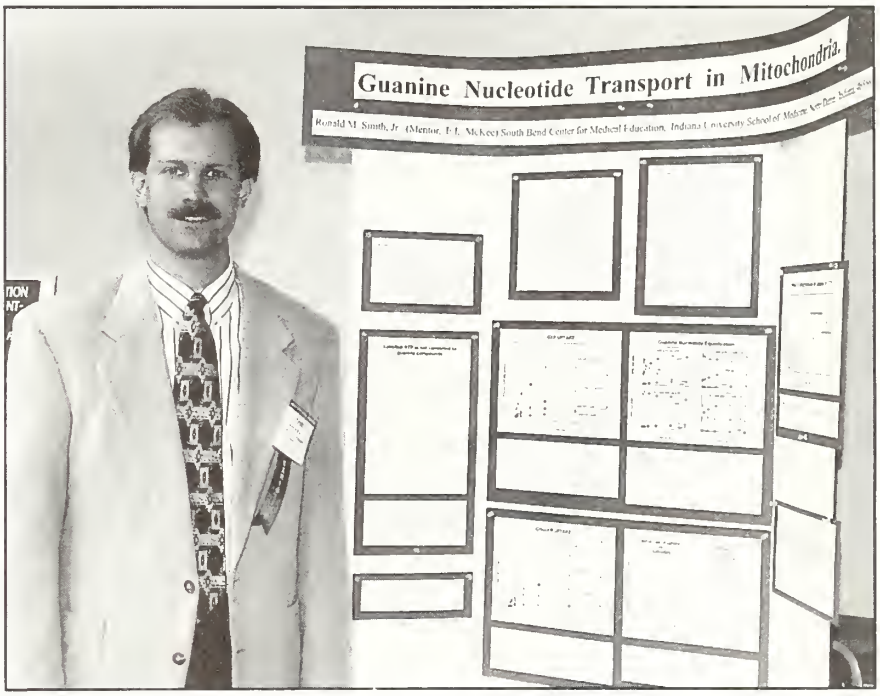
Scientific exhibit winners

First place

"Guanine nucleotide transport in mitochondria"

Exhibitors: Ronald M. Smith Jr., South Bend Center for Medical Education, Dept. of Biochemistry and Molecular Biology, Indiana University School of Medicine; and Edward E. McKee, Ph.D., Dept. of Biological Science, Notre Dame, South Bend, Ind.

The transport of adenine nucleotides in mitochondria has been well characterized; however, much less is known concerning mitochondrial transport of guanine nucleotides. Although past research has failed to find a transport mechanism, the requirement for GTP in RNA translation and DNA transcription as well as the fact that GDP is involved in the TCA cycle indicates that guanine nucleotides must be transported into the mitochondrial matrix. Previous work with isolated intact rat heart mitochondria has indicated that neither guanine nor guanosine are transported into the matrix. In the present work, it has been shown that when radiolabelled GTP is added to an incubation medium there is net transport into the matrix. Because of the rapid interconversion between the phospho forms of the nucleotide, it is not clear which form is actually transported, although kinetic studies seem to indicate that it is most likely GDP. Unlike the ATP transport mechanism, this uptake is not inhibited by atractyloside. Studies have indicated a rate of transport around 88 pmole/mg/min. ❑



Ron Smith stands with his award-winning exhibit.

Second place

"APC resistance as measured by a textarin time assay: Comparison to the APTT-based method"

Exhibitor: Lee E. Hoagland and D.A. Triplett, Muncie Center for Medical Education, Indiana University School of Medicine, Research Department, Ball Memorial Hospital, Muncie, Ind.

Protein C is a major regulatory protein critical to physiologic anticoagulation. Once activated, it selectively degrades the activated forms of factors V and VIII, thereby inhibiting blood coagulation. Using an activated partial thromboplastin time (APTT) assay, Dahlback et al recently reported that some individuals, especially those with previous thrombotic episodes or a family history of venous thrombosis, show a poor anticoagulant response to activated protein C (APC). In an attempt to develop a more sensitive and specific test system, we decided to evaluate an assay based on Textarin®. Textarin®, a protein fraction of *Pseudonaja textilis* venom (Australian Eastern brown snake), activates prothrombin in the presence of phospholipid (PL), factor V and calcium ions. Based on its factor V dependance, we have developed a Textarin Time assay to test for APC resistance. We have evaluated this test system

in normal subjects and in the following patient populations: stable oral anticoagulated and known APC resistance. Our data conclude that the Textarin Time assay is an effective screening system that can be used to detect APC resistance due to factor V abnormalities. ❑

Third place

"A comparison of criteria for pretransplantation crossmatching: Flow cytometry versus complement-dependent cytotoxicity"
Exhibitors: Richard Y. Ha, Benita K. Book, Richard A. Sidner, Ronald S. Filo, Division of Organ Transplant, Department of Surgery, Indiana University School of Medicine, Indianapolis, Ind.

The complement-dependent cytotoxic crossmatch (CDCXM) measures humoral activity against a donor's lymphocytes. Levels of cytotoxicity (CTX) are assigned as 1, 2, 4, 6 or 8 corresponding to the percentage of cell death: 0-10, 11-20, 21-50, 51-80, 81-100, respectively. A positive CDCXM (≥2) contraindicates transplantation and is a predictor of humoral rejection. The flow cytometry crossmatch (FCXM) measures binding of alloantibodies rather than CTX and is reportedly more sensitive than CDCXM. Cellular immunofluorescence is expressed as Mean Channel Shift (MCS), with higher MCS indicating greater levels of bound alloantibody. Furthermore, the FCXM can identify particular class(es) of reacting antibody (IgG, IgM) and the type of target cells (B, T, MO). In this study, we compared the two methods to discern the relationship between FCXM and CDCXM values and to establish ranges of MCS within each cytotoxicty level in CDCXM. CDCXM's were performed using sera obtained from potential renal graft recipients and unseparated cell preparations from donor lymph nodes; parallel FCXM's were performed using preparations of donor spleen lymphocytes. We analyzed the following interactions: IgG vs. T-cells (GT); IgG vs. B-cells (GB); IgM vs. T-cells (MT); IgM vs. B-cells (MB). For each CTX level, a group mean MCS was calculated. Statistical analyses used factorial ANOVA with Fisher's PLSD post-hoc interactions test.

IgG reactivity (GT and GB) was directly related to CTX levels. Group means in the GT series were significantly different except when comparing CTX levels 1 and 2, and CTX levels 2 and 4. For the GB series, group means were significantly different except between levels 1 and 2, 2 and 4, and 6 and 8. For the MT series, only group mean for CTX level 8 differed significantly. Group means were not significantly different for the MB series. ❑

Mean Channel Shifts (mean ± s.e.)

CTX (n)	GT (p<.0001)	GB (p<.0001)	MT (p≥.010)	MB (p≥.76)
1 (23)	2.0 ± 2.0	6.4 ± 3.6	2.3 ± 1.5	16.6 ± 3.5
2 (18)	11.4 ± 4.9	23.8 ± 8.3	2.3 ± 1.8	13.9 ± 3.7
4 (21)	22.4 ± 5.8	38.8 ± 8.0	5.4 ± 2.8	15.7 ± 4.5
6 (18)	41.4 ± 8.2	71.3 ± 8.3	2.3 ± 1.7	11.9 ± 2.1
8 (16)	71.4 ± 8.9	81.7 ± 9.8	16.1 ± 6.3	19.6 ± 5.9

Editor's note: These annual reports were not submitted in time to be included in the September/October 1995 issue of Indiana Medicine.

FIFTH DISTRICT
Fred Haggerty, M.D., trustee

The Fifth District annual meeting was held at the Walden Inn in Greencastle May 25 with a good turn-out. Next year's annual meeting is scheduled in Clay County.

Quarterly meetings have continued, actively providing opportunity to share concerns, to network and to solve common problems.

Again Janna Kosinski, the ISMA field representative, has helped the district greatly. Thank you.

10TH DISTRICT
Thomas Brubaker, M.D., trustee

Activities in the 10th District were not unusual this year. We maintained the same schedule of meetings and continued the excellent level of communication between the two counties in the district.

Overall our membership has increased, with both counties developing and pursuing efforts to obtain new members and retain past members. Each county has attempted to address the special issues facing our area – the growth of managed care entities. We made some preliminary efforts to develop a joint managed care program. Activities in this area are ongoing in both counties.

We also held several joint membership programs on Medicaid reform and managed care programs. We have pursued an annual legislative meeting with state legislators since some legislators overlap portions of each county. Some of our members also met with Congressmen.

The two counties are represented by a liaison who attends each county's board and membership meetings. We are fortunate to have active members from both areas who participate in the ISMA and share information. We also work closely on resolutions and legislation.

During the last 10th District meeting, Frank Hieber, M.D., was elected president; Floyd Manley, M.D., treasurer; and Thomas Brubaker, M.D., trustee. A resolution establishing a 10th District legislative committee was adopted. The legislative committee would consider any legislative or regulatory matter of interest to our members, develop a position, meet with legislators, present seminars and participate in IMPAC and the ISMA Legislative Commission.

Next year, the 10th District will undertake more joint efforts. As we learn that issues are not just community wide, we will continue to use the strength in unity of effort.

13TH DISTRICT
Alfred Cox, M.D., trustee

The 13th District's annual meeting was hosted by St. Joseph County at Morris Park Country Club, South Bend, March 22. District president, Donald Smith, M.D., presided over the evening's activities, which included the election of a new district trustee, Richard Houck, M.D., Michigan City, and a new alternate trustee, David Hornback, M.D., South Bend. Entertainment was provided by Don Hall, a local magician. The attendance was not as good as we hoped; however, I feel this represents physicians' apathy throughout organized medicine. We need to make our membership more aware of the legislative medical issues and the role we can have in shaping our destiny.

The annual meeting was moved to the spring so that the issues of the state legislature could be addressed. Our organization was very successful in dealing with medical concerns in the recent legislative session.

As I move on to a state leadership position, I know that Drs. Houck and Hornback will provide outstanding leadership for the members of the 13th District on the board of trustees. ❑

resolutions

Resolution 95-1	**Statewide Medical Education**
Introduced by:	Dearborn-Ohio County Medical Society
Referred to:	Reference Committee 1
Action:	Not adopted

Whereas, the Indiana University of Medicine statewide system for medical education, initiated the system in 1970; and

Whereas, the eight outstanding campuses are located in the north and west portions of the state; and

Whereas, the southeast one-third of the state has no such centers; and

Whereas, such benefits as physician recruitment, physician retention and continuing medical education, may benefit from medical education centers; therefore be it

RESOLVED, The ISMA, in conjunction with the statewide system of Medical Education, support an updated feasibility study to develop a ninth Medical Education Center in the southeast one-third of the state, so that the statewide system of Medical Education will be truly statewide.

RESOLUTION 95-2	**ISMA Commission on Sports Medicine**
Introduced by:	The ISMA Executive Committee
Referred to:	Reference Committee 1
Action:	Not adopted

Whereas, Section 7.010205 states that the Commission on Sports Medicine

encompasses the field of sports medicine; and

Whereas, Section 7. 10007 states,

> "The Commission on Sports Medicine shall provide liaison between the Indiana State Medical Association and various athletic organizations. The Commission will research issues and make recommendations in a variety of areas relating to sports medicine in our state, in an attempt to improve the medical care of Indiana athletes and related personnel"; and

Whereas, these policy areas are addressed by the Commission on Legislation and other ad hoc committees established from time to time to serve specific purposes; and

Whereas, it is important that the ISMA, as an organization led by busy volunteers, strive to make the best and most efficient use of our members' time who generously agree to serve on commissions and committees; therefore be it

RESOLVED, That Section 7.010205 and Section 7.10007 be deleted from the Bylaws, and in lieu thereof, specific ad hoc committees be created for special purposes as the need arises.

RESOLUTION 95-3	**Commission on Physician Assistance**
Introduced by:	The Commission on Physician Assistance
Referred to:	Reference Committee 1
Action:	Adopted

Whereas, Section 7.1006 of the ISMA Bylaws states as follows,

> "Commission on Physician Assistance: The Commission on Physician Assistance shall develop a program to recognize, treat and rehabilitate physicians who are in need of assistance because of neuropsychiatric illness, physical infirmities, or alcohol and other substance dependence. The Commission will encourage informal and formal referral of all physicians in need of assistance to component county medical society screening committees."; and

Whereas, the Commission on Physician Assistance meets all the requirements of Indiana's "Peer Review Act," as set forth at I.C. 34-4-12.6-1 et al; and

Whereas, the Indiana Peer Review Act provides various confidentiality, privilege and immunity protections; and

Whereas, it could be advantageous to the Commission to have stated in the ISMA Bylaws that the Commission on Physician Assistance is a "peer review committee" as defined by the Indiana Peer Review Act, and claims all the privileges and immunities contained therein; therefore be it

RESOLVED, That the ISMA Constitution and Bylaws, Section 7.1006, be amended by adding the following language,

> "The ISMA Commission on Physician Assistance is organized pursuant to Indiana's Peer Review Act as set forth at I.C. 34-4-12.6-1 et al, and claims all the rights, privileges, confidentiality and immunities provided therein."

RESOLUTION 95-4 **HIV Testing of Pregnant Women**

Introduced by: John W. Luce, M.D., Michigan City
Referred to: Reference Committee 2
Action: Adopted

Whereas, many pregnant women are unaware of their HIV status; and

Whereas, there is scientific evidence that transmission of the HIV virus takes place between an infected mother and her unborn child; and

Whereas, there is mounting evidence to suggest that maternal treatment with zidovudine can significantly reduce the vertical transmission rate from 26% to 8%; therefore be it

RESOLVED, That the ISMA seek legislation to require HIV testing of all pregnant women.

RESOLUTION 95-5 **Third-Party Reimbursement for Pre-certification**

Introduced by: Third District Medical Society
Referred to: Reference Committee 4
Action: Adopted as amended

Whereas, most of the insurance companies, Medicare and Medicaid, now require precertification for diagnostic tests, consultations, procedures and surgeries; and

Whereas, this is entirely for the benefit of the third parties and does nothing to improve the quality of care, and sometimes actually impairs the quality of care; and

Whereas, the physicians have been forced to bear the brunt of the extra cost for these precertifications, including the hiring of extra personnel, or tying up the time of present personnel, and it results in hours of wasted time; and

Whereas, many times the third parties needlessly extend these calls with unnecessary questions and cause excessive waste of time and frustration by placing the caller on hold and requiring that we talk to more than one person; therefore be it

RESOLVED, That the ISMA support the concept of reasonable reimbursement of management services such as: precertification for diagnostic tests, consultation, procedures and surgeries; and be it further

RESOLVED, That the ISMA communicate this resolution to the AMA for their support.

RESOLUTION 95-6 **ISMA Commission on Legislation Participation**

Introduced by: Barney R. Maynard, M.D., Chair, ISMA Commission on Legislation
Referred to: Reference Committee 1
Action: Adopted

Whereas, the need for physicians to speak with a unified voice has never been greater; and

Whereas, the need to speak with a unified voice on legislative matters is absolutely critical to the protection and advocacy for patients and our profession; and

Whereas, all elements of medicine need to work together on common legislative matters to more effectively advocate for patients and physicians; and

Whereas, the ISMA Commission on Legislation is open to all physician members and desires input from all physicians and specialties; therefore be it

RESOLVED, That every member of the ISMA be welcomed at the meetings of the Commission on Legislation, and that their input be actively sought and recognized.

RESOLUTION 95-7 **ISMA-Sponsored Self-Funded HMO**

Introduced by: Rami Saydjari, M.D. Crawfordsville
Referred to: Reference Committee 1
Action: Resolution 95-29 adopted in lieu of Resolution 95-7

Whereas, physicians and patients face ever increasing interference with the doctor/patient relationship by managed care entities; and

Whereas, recent court decisions have confirmed that some managed care entities make fiduciary decisions which are not always in the best interest of the patient and may adversely affect medical outcomes; and

Whereas, successful self-funding HMOs sponsored by a state medical society have been created in the past (e.g,. Physician Health Care Plan of New Jersey and M.D. Health Plan of Connecticut); and

Whereas, eliminating insurance companies as the middleman in health care is likely to protect the doctor/patient relationship and restore the doctor's role as patient advocate while controlling cost within the context of a physician-owned and physician-run HMO; therefore be it

resolutions

RESOLVED, That the ISMA undertake a feasibility study to determine whether an ISMA-sponsored HMO would be efficacious in Indiana and report back the findings of such a study to ISMA members.

RESOLUTION 95-8	**Insurance Coverage for Deliveries**
Introduced by:	John W. Luce, M.D., Michigan City
Referred to:	Reference Committee 4
Action:	Referred to Board of Trustees

Whereas, many third party payers are reducing the length of stay for routine deliveries to one night stays; and

Whereas, the American College of Obstetricians and Gynecologists in its 1992 "Guidelines for Prenatal Care," recommends that in otherwise uncomplicated deliveries the postpartum stay range from 48 hours for vaginal delivery to 96 hours for cesarean section; and

Whereas, the decision to discharge a woman after deliveries lies with the woman and her physician; and

Whereas, other state legislatures, including Maryland and New Jersey, have required third-party payers to follow the American College of Obstetricians and Gynecologists Guidelines; therefore be it

RESOLVED, That the ISMA support legislation that would require third-party payers to pay for at least 48 hours of hospital care after a routine delivery and 96 hours after a cesarean section.

RESOLUTION 95-9	**Physician filing and signing of certificate of birth and death**
Introduced by:	The Indiana Association of Public Health Physicians Joseph Black, M.D., health officer, Jackson County Joe Dukes, M.D., former health officer, Sullivan County
Referred to:	Reference Committee 2
Action:	Adopted

Whereas, the current birth registration law IC 16-37-2-1 defines "a person in attendance at birth" as a licensed physician, or midwife, or other legally authorized person to attend a patient in childbirth; and

Whereas, the current death registration law IC 16-37-3-5 specifies the physician last in attendance . . . shall certify the cause of death or stillbirth; and

Whereas, the State Department of Health has elected to designate other than a physician/midwife to sign a birth certificate; and

Whereas, there are conflicting laws that specify that lay people can certify the cause (medical) of death; therefore be it

RESOLVED, That the ISMA seek and support legislation that would:

1) Amend birth and death registration laws to specify physician responsibility for signing and filing a birth and death certificate:

a) Designate that only a physician holding an unlimited license to practice medicine, a licensed midwife or the local health officer are legally authorized to file a birth certificate.

b) Designate a physician holding an unlimited license to practice medicine as the only person legally authorized to certify a medical cause of death and to file a death certificate.

RESOLUTION 95-10	**ISMA Medicare Transformation Position**
Introduced by:	Barney R. Maynard, M.D., alternate delegate to AMA
Referred to:	Reference Committee 3
Action:	Adopted as amended

Whereas, the Medicare program has, for thirty years, served to finance the health care needs of the elderly and disabled; and

Whereas, the Medicare program has attained the original goals of providing quality health care and access to all of its beneficiaries; and

Whereas, the Medicare program was based on an unsustainable financial foundation; and

Whereas, the Medicare program now faces bankruptcy and chaos unless radical measures are taken; and

Whereas, the American Medical Association, at its recent annual meeting, adopted a bold and comprehensive plan to completely transform the Medicare system; and

Whereas, this plan has been presented to the Congress of the United States for consideration and adoption; therefore be it

RESOLVED, That the ISMA adopt as policy on Medicare, the proposals of the AMA's 1995 Transforming Medicare; and be it further

RESOLVED, That the ISMA through its membership, leadership and Commission on Legislation, aggressively lobby for passage of the AMA's 1995

Transforming Medicare with the Indiana Congressional Delegation.

RESOLUTION 95-11 **Testing for human immunodeficiency virus (HIV)**

Introduced by: Fort Wayne Medical Society
Referred to: Reference Committee 2
Action: Adopted

Whereas, *The New England Journal of Medicine* reported in August of 1992 that:

1) 1,000,000 American citizens are infected with the HIV virus and many are not aware of it;

2) 110,000 or 11% of those who carry the virus unknowingly could be identified in one year of hospital testing;

3) 200,000 HIV-infected patients are treated annually in the nation's 5,558 hospitals;

4) 134,000 HIV-infected patients treated in the nation's 5,558 hospitals will be treated for symptoms unrelated to this virus; and

Whereas, early detection and treatment will benefit those who are infected and guard against their infecting others; and

Whereas, the highest incidence of HIV infection occurs between ages 15 and 54; and

Whereas, physicians and health care entities are required to go to great lengths to ensure the protection of others, but are prevented by that same law (except under court order or emergency) from carrying out the necessary steps of good, prudent medical care and disease prevention due to informed consent laws and laws of confidentiality that prevent a physician from testing or informing emergency, nursing, surgical or other medical staff of a patient's HIV status; therefore be it

RESOLVED, That the ISMA petition the 1995 session of the Indiana General Assembly to pass legislation requiring hospitals to routinely offer voluntary HIV testing of all patients between the ages of 15 and 54 who are seen in Indiana hospitals.

RESOLUTION 95-12 **Consolidation of "Subcommission on Accreditation"**

Introduced by: Glenn J. Bingle, M.D., Chairman, Commission on Medical Education
Referred to: Reference Committee 1
Action: Adopted

Whereas, Section 7.1005 of the ISMA Bylaws states,

> ". . . The Commission on Medical Education with the assistance of the Subcommission on Accreditation shall serve as the ISMA state's accrediting body to accredit institutions and organizations for the presentation of intrastate continuing medical education programs"; and

Whereas, the Commission on Medical Education recommends the elimination of a separate Subcommission on Accreditation, thereby reducing redundancy and streamlining the ISMA accreditation process; and

Whereas, combining the two entities into one, named the Commission on Medical Education, would also provide maximum efficiency and continuity within the entities; therefore be it

RESOLVED, That Section 7.1005 be amended to read as follows:

> "The Commission on Medical Education shall maintain liaison with, and be of assistance to, medical schools and the Medical Licensing Board. It shall keep in contact with and endeavor to assist in improving and maintaining high quality undergraduate, graduate and continuing medical education and public school health education within the state. The Commission on Medical Education shall serve as the ISMA's state accrediting body to accredit institutions and organizations for the presentation of intrastate continuing medical education programs."

RESOLUTION 95-13 **Tobacco control task force**

Introduced by: Stephen J. Jay, M.D., Indianapolis
Referred to: Reference Committee 2
Action: Adopted as amended

Whereas, science has proven that tobacco use causes numerous health hazards; and

Whereas, physicians should educate their patients and the public on the risks associated with tobacco usage and the health benefits of quitting tobacco; and

resolutions

Whereas, physicians need to improve their effectiveness in preventing children from starting tobacco usage and in helping individuals and their families to quit; therefore be it

RESOLVED, That the ISMA create a tobacco control task force and the duties of the task force shall include, but not be limited to, the following:

1. Promote public policy that will especially prevent youth access to tobacco; and

2. Support smoke free indoor air legislation and regulation at local, state and national levels; and

3. Enhance physician education and awareness, especially training of medical students and residents in tobacco control; and

4. Provide training for practicing physicians to be able to teach smoke cessation skills to others; and

5. Publicize the importance of tobacco control through articles for *Indiana Medicine* and *ISMA Reports*; and

6. Collaborate with other organizations such as the Indiana Department of Health, Indiana University School of Medicine and Project ASSIST (America Stop Smoking Intervention Study).

7. Contribute to the ISMA policy on tobacco control by sponsoring or supporting resolutions regarding tobacco control.

RESOLUTION 95-14 **Support for Project Solo**

Introduced by: Steven Isenberg, M.D., Indianapolis

Referred to: Reference Committee 4

Action: Adopted as amended

Whereas, physicians desire to provide quality care for their patients at reasonable cost; and

Whereas, physicians desire to remain advocates for their patients without conflict of interest; and

Whereas, Project Solo is a non-profit, non-partisan, grassroots organization of independent physicians united for quality, autonomy, patient advocacy and cost containment; therefore be it

RESOLVED, That the ISMA endorse Project Solo.

RESOLUTION 95-15 **Medicare/Medicaid coalition meetings**

Introduced by: Jasper/Newton County Medical Society
Kenneth J. Ahler, M.D.

Referred to: Reference Committee 1

Action: Resolution 95-16 was adopted as amended in lieu of Resolution 95-15 and 95-20

Whereas, a number of years ago, the ISMA was able to develop a meeting format between the carriers and providers to deal with reimbursement issues, especially for Medicare and Medicaid; and

Whereas, these meetings were especially designed to provide dialogue between the carriers and providers in an open format to resolve issues of conflict and reimbursement; and

Whereas, representation from various organizations, including aging senior citizens, congressional offices, specialty societies, as well as individual office practices, were all invited and welcomed; and

Whereas, members from consulting firms representing physician clients of societies have attended these meetings from their inception; and

Whereas, issues concerning reimbursement coding, policy changes, computer problems and payment delays continue to arise as both Medicare and Medicaid re-evaluate their reimbursement policies; and

Whereas, the ISMA reports that the cost of sponsoring these meetings has escalated significantly; and

Whereas, the physical location has become inadequate due to the number of attendees; and

Whereas, a charge of attendance has been levied to certain attendees of these meetings which they consider sufficient to perhaps limit their attendance; therefore be it

RESOLVED, That the Medicare/Medicaid Coalition meetings be continued in their original format; and be it further

RESOLVED, That the Medicare/Medicaid Coalition meetings be open to any representatives having concerns with carrier (payer) provider issues and/or reimbursement issues; and be it further

RESOLVED, That the Medicare/Medicaid Coalition meetings be moved to a facility large enough to accommodate the attendance; and be it further

RESOLVED, That the ISMA research means of financially supporting this facility without charging attendees.

RESOLUTION 95-16 **Medicare/Medicaid coalition meeting**

Introduced by: C.G. Clarkson, M.D., Richmond
Referred to: Reference Committee 1
Action: Adopted as amended in lieu of Resolutions 95-15 and 95-20

Whereas, Indiana Medicare and Medicaid oversight coalition meetings were developed in a roundtable type format to provide dialogue between providers, patients and carriers to deal with problems of HCFA, the carriers, the providers and the patients; and

Whereas, the ISMA sponsored these meetings in that original format until recently; and

Whereas, the ISMA Executive Committee and Board decided to make changes considered exorbitant to certain attendees of these meetings; and

Whereas, this has caused discourse and threatened to disturb the original intent of the meeting format; and

Whereas, the ISMA cites cost and facility size as the reason for the fees; therefore be it

RESOLVED, That the Medicare/Medicaid Coalition meeting be continued in a format to provide dialogue between all participants; and be it further

RESOLVED, That the ISMA research means to financially support and move the meetings to a facility where attendance is not limited and charges, if made, are reasonable.

RESOLUTION 95-17 **Freedom of choice for dermatological services**

Introduced by: Indiana Dermatological Society
Cleve Francoeur, M.D.
Referred to: Reference Committee 3
Action: Adopted as amended with substitute resolve

Whereas, the American Medical Association, the ISMA and the Indiana Dermatological Society all support the right of patients to access the physician of their choice; and

Whereas, unlike other specialties, on average, 90% of patients currently access dermatologists directly without a referral; and

Whereas, dermatological disorders, unlike vague internal medical problems, are readily evident to patients, thus allowing appropriate self-referral without the need for gatekeeper direction; and

Whereas, unlike other specialties, essentially all patients currently under the care of a dermatologist will, against their will, lose continuity of care with their dermatologist and be forced to see providers unfamiliar with their diagnosis and special needs; and

Whereas, in the specialty of dermatology, the arguments of managed care corporations for gatekeeper services in the areas of cost effectiveness, patient satisfaction and quality of care are not applicable; and

Whereas, many managed care plans utilizing gatekeepers place more emphasis on profit than on the quality of care, and thus prevent patients from obtaining expert level dermatological care for their skin, hair and nail disorders; and

Whereas, by supporting and passing HB 1257 in the 1993 Indiana General Assembly, the ISMA, State Legislature and Governor have previously affirmed their support for policy allowing direct access to dermatologists or primary care providers for dermatological services; therefore be it

RESOLVED, That the ISMA support legislation to ensure that patients have the right to choose their physician.

RESOLUTION 95-18 **Minimize capitation use in health care insurance reform**

Introduced by: Fort Wayne Medical Society
Referred to: Reference Committee 4
Action: Adopted as amended

Whereas, in the climate of health care reform, the merging of the delivery and financing of health care has evolved; and

Whereas, the traditional fee for service system has and will be changing to a capitated form of payment; and

Whereas, there are many references in managed care literature that capitation may create ethical dilemmas for physicians in administering good quality, competent health care to patients; and

Whereas, the physicians of the ISMA are dedicated towards working in their patients' best interest without serious economic conflict; therefore be it

RESOLVED, That the ISMA work with the Indiana legislature to implement health care insurance reform for Indiana citizens that will minimize the use of capitation, thus ensuring benefit for Indiana patients; and be it further

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RESOLVED, That ISMA educate the citizens of Indiana about capitation and how providers are incentivized under capitation, as appropriate.

RESOLUTION 95-19	**Class IV Health Professions Bureau Regulations**
Introduced by:	Dennis W. Miller, M.D., Indianapolis
Referred to:	Reference Committee 3
Action:	Adopted as amended

Whereas, the Health Professions Bureau restricts the prescribing of Class IV appetite suppressants; and

Whereas, such restrictions allow for substantially less care than is allowed under the DEA regulation; and

Whereas, these HPB regulations compromise effective treatment in some patients; therefore be it

RESOLVED, That the ISMA encourage the Medical Licensing Board of Indiana to change their rule on prescribing Class IV appetite suppressants to allow scientifically justified treatment options.

RESOLUTION 95-20	**ISMA Medicare/Medicaid meeting**
Introduced by:	Louis Cantor, M.D., Indianapolis
Referred to:	Reference Committee 1
Action:	Resolution 95-16 was adopted as amended in lieu of Resolution 95-15 and 95-20

Whereas, Indiana physicians continue to have problems with Medicare and Medicaid; and

Whereas, the Medicare/Medicaid coalition meetings are a forum to exchange information with the representatives of Medicare and Medicaid on the problems physicians are experiencing; and

Whereas, this forum is utilized to solve these problems; and

Whereas, the free flow of information between the physician community and representatives of Medicare and Medicaid should continue; therefore be it

RESOLVED, That the forum should be continued in its original format; and be it further

RESOLVED, That members in good standing with the ISMA should be allowed to appoint representatives, who might not be their direct employee, to attend the coalition meeting on their behalf at no charge.

RESOLUTION 95-21	**Non-board certified members as members of managed care plans**
Introduced by:	C.G. Clarkson, M.D. Indiana Academy of Family Physicians
Referred to:	Reference Committee 4
Action:	Adopted as amended

Whereas, family physicians are trained in a variety of medical specialty areas, including internal medicine, pediatrics, surgery (general and subspecialty), obstetrics and gynecology, dermatology, psychiatry and emergency medicine; and

Whereas, active members of the Indiana Academy of Family Physicians are required to secure 150 hours of approved CME every three years for continued membership; and

Whereas, the wide range of skills possessed by family physicians and the frequent opportunities to use them in their practices enables family physicians to be highly cost-effective and have excellent patient satisfaction; and

Whereas, numerous managed care organizations have established board certification as a criteria for membership; therefore be it

RESOLVED, That the ISMA join in a statewide effort with the Indiana Academy of Family Physicians to ensure that board certification not be used as the sole criteria for acceptance by a managed care organization.

RESOLUTION 95-22	**Reimbursement of screening studies**
Introduced by:	Thomas Kintanar, M.D. Indiana Academy of Family Physicians
Referred to:	Reference Committee 4
Action:	Adopted

Whereas, the continuing health care and welfare of our patients is of paramount concern to practicing physicians; and

Whereas, it is recognized that in certain patients, age and population demographic data have proven that certain populations are predisposed to certain disease processes (i.e. family history of colon cancer, heart disease, numerous risk factors, etc); and

Whereas, it has been recognized in many practicing clinicians' offices that the patients are finding it more and more difficult to get insurance reimbursement for

"screening tests"; therefore be it

RESOLVED, That the ISMA advocate that third party payers reimburse for screening studies that are scientifically supported (such as those from the U.S. Task Force on Preventive Services).

RESOLUTION 95-23 **Resident Medical Society membership**

Introduced by: Resident Medical Society
Referred to: Reference Committee 4
Action: Adopted

Whereas, there currently exists a membership structure for resident physicians such that residents who currently hold membership in the Resident Medical Society of the ISMA do not hold membership in the county or district medical societies; and

Whereas, resident participation in organized medicine is a strong predictor of future membership; and

Whereas, the Resident Medical Society wishes to bring together all residents in the state to improve Federation recruitment of resident physicians and create a better communication link with the county and district medical societies; and

Whereas, the Resident Medical Society currently gains a delegate to the ISMA House of Delegates for every 50 members; and

Whereas, there is presently no mechanism for incoming residents and fellows to join for the six months (July through December) of their first year in Indiana unless they are senior medical students who just graduated from the Indiana University School of Medicine; and

Whereas, a one-time membership fee for county, district and state dues would attract more resident members and has proven to be effective through a previous pilot program where a one-time fee for state dues was implemented; therefore be it

RESOLVED, that all resident physicians, who hold membership in the Resident Medical Society or the county and district medical society, be required to hold membership in the Resident Medical Society of the ISMA and the county and district medical societies, with county medical society membership to be held in the county in which the resident lives or works; and be it further

RESOLVED, That the RMS have 4 delegate votes in the ISMA House of Delegates, and the resident members also be counted by the county medical societies where the residents hold membership, for determination of the number of delegates allowed for that component society if they meet the requirements of the ISMA Constitution & Bylaws; and be it further

RESOLVED, That the state dues structure be changed so that all new members who are residents or fellows, no matter how long they have been in training, pay a one-time fee to the ISMA, which would cover their dues for the entire training period; and be it further

RESOLVED, That all new members who are residents or fellows in Indiana be exempt from paying county, district and state dues from July to December of the year they become a member; and be it further

RESOLVED, That this resolution shall not apply to any residents or fellows who have already joined the Resident Medical Society or the county medical society prior to the adoption of this resolution.

RESOLUTION 95-24 **Repeal of mandated third trimester syphilis testing for pregnant women**

Introduced by: John Denton, M.D., Anderson
Referred to: Reference Committee 2
Action: Adopted

Whereas, a syphilis test is required to be performed in the first trimester of pregnancy; and

Whereas, a third trimester test is not clinically necessary and is costly and inconvenient for patients; and

Whereas, the guidelines of the Indiana State Department of Health, Division of Maternal and Child Health, only require that a serologic screening for syphilis be performed on the initial prenatal care visit; and

Whereas, the Medicaid administration in Indiana only covers a third trimester test if the first trimester test was positive; and

Whereas, the Medicaid administration based the aforementioned policy on the directives of the American College of Obstetrics and Gynecology and the American Academy of Pediatrics; and

Whereas, the American College of Obstetrics and Gynecology and the American Academy of Pediatrics direct that a third trimester test should only be ordered for members of a high-risk population; therefore be it

RESOLVED, That the ISMA introduce a bill to the General Assembly for the 1996 legislative session to repeal the language of the Indiana Code (16-41-15-10)

that unnecessarily requires the standard serological test for syphilis for women in third trimester of pregnancy.

RESOLUTION 95-25 **Do-not-resuscitate policy**
Introduced by: Lake County Medical Society
Martha Mechei, M.D.
Referred to: Reference Committee 2
Action: Referred to Board of Trustees

Whereas, a statewide uniform Do Not Resuscitate (DNR) policy for use of emergency medical services (EMS) personnel does not exist in Indiana; and

Whereas, such a policy would benefit all EMS personnel by application of a consistent medical standard; and

Whereas, other states have such a policy; and

Whereas, Indiana should develop such a policy: therefore be it

RESOLVED, That the ISMA develop legislation providing for a DNR policy for statewide use of basic and advanced life support personnel in the local EMS.

RESOLUTION 95-26 **Practice limitations**
Introduced by: Lake County Medical Society
Vijay Dave, M.D.
Referred to: Reference Committee 1
Action: Adopted

Whereas, the ability to practice medicine in a hospital is based upon professional staff determination of privileges; and

Whereas, once the privilege is extended its maintenance is appropriately part of professional staff responsibility; and

Whereas, a hospital board may have ultimate responsibility for privileges should the professional staff fail to carry out its responsibility; and

Whereas, no person's privileges should be restricted prior to appropriate professional review and recommendation; and

Whereas, hospitals may attempt to circumvent such review and recommendation by utilizing economic and contractual criteria without regard for individual quality; and

Whereas, such attempts are contrary to the intent and spirit of professional staff bylaws; therefore be it

RESOLVED, That the AMA support model hospital-medical staff bylaws requiring the same due process in limiting professional practice for economic or contractual reasons as is followed for quality reasons; and be it further

RESOLVED, That the AMA clarify that practice limitations based on economic or contractual reasons are not reportable to the Physicians Data Bank.

RESOLUTION 95-27 **Standard accounting format**
Introduced by: Lake County Medical Society
Frank Hieber, M.D.
Referred to: Reference Committee 3
Action: Adopted as amended

Whereas, managed care entities are becoming widespread throughout Indiana; and

Whereas, many of these entities are businesses; and

Whereas, entities organized for profit may emphasize profit over service; and

Whereas, it is in the public interest to know the extent of profit as compared to the cost of services; and

Whereas, a public reporting system would be most expeditious; therefore be it

RESOLVED, That the ISMA determine:

1. Whether the insurance commissioner has developed a standard accounting format for use by any HMO, PPO or other managed care program operating within the state; and

2. Whether all such programs utilize such standard accounting formats for purposes of reporting; and

3. Whether each such program reports on the standard format its annual income and expenses clearly showing its annual and cumulative surplus due to health care services provided within the state; and be it further

RESOLVED, That the ISMA actively seek the information regarding annual insurance company financial disclosure for dissemination to members as appropriate.

RESOLUTION 95-28 **Release of medical information**
Introduced by: Thomas Brubaker, M.D., Griffith
Referred to: Reference Committee 3
Action: Withdrawn by author

Whereas, third party payers, such as insurance companies, frequently require information to support claims for payment; and

Whereas, the standard is to obtain consent for release of medical information; and

Whereas, direct payment from patients is often

illegal (such as in Worker's Compensation, Medicare and Medicaid) and prohibited by some managed care contracts; therefore be it

RESOLVED, That the ISMA work for legislation that prohibits revocation of a consent for release of information to payers once services have been rendered unless payment for services has occurred.

RESOLUTION 95-29 **Physician owned or operated managed care programs**

Introduced by: Lake County Medical Society
Thomas Brubaker, M.D.
Referred to: Reference Committee 1
Action: Adopted in lieu of Resolution 95-7

Whereas, managed care entities of all kinds are becoming more widespread throughout Indiana; and

Whereas, managed care entities are formed and operated by many different parties of interest; and

Whereas, entities can be organized entirely for profit and operated for financial benefit of individuals not providing care; and

Whereas, it would be in the best interest of providers and patients to assure that managed care entities are controlled by those having the quality care interests of the patient as the primary goal; and

Whereas, a statewide entity could best serve the patient care interests of the physicians of Indiana; and

Whereas, the ISMA can serve as a catalyst for developing patient friendly organizations; and

Whereas, an excessive percentage of premium is frequently retained for industry profits; therefore be it

RESOLVED, That the ISMA investigate the creation of regional or statewide managed care programs, owned and operated, at least in part, by the physicians of Indiana; and be it further

RESOLVED, That this resolution be referred to the Board of Trustees for appropriate implementation.

RESOLUTION 95-30 **Limiting physician participation**

Introduced by: Lake County Medical Society
Nicholas Polite, M.D.
Referred to: Reference Committee 3
Action: Not adopted

Whereas, public funds (including Medicaid) are available to the Healthy Start Program; and

Whereas, part of that program pays for delivery by contracted physicians; and

Whereas, such physician payments (which do not include physician prenatal care) are more than for direct Medicaid payment (which requires prenatal care); and

Whereas, not all qualified physicians who would like to participate may contract with Healthy Start to provide services; and

Whereas, such denial of participation is improperly discriminatory and restrictive of quality care; therefore be it

RESOLVED, That the ISMA support legislation and regulations preventing differing Medicaid payment levels for similar services by the same medical specialty, based upon any plan limiting open participation by all members of the specialty meeting the qualifications; and be it further

RESOLVED, That the ISMA support changes to Indiana legislation and regulations to require a program, like Healthy Start, to allow any physician qualified and willing to provide medical services, like those provided under the program, to participate to the same extent as any other physician in the program.

RESOLUTION 95-31 **Physician protection against managed care retaliation for acting as patient advocates**

Introduced by: Fort Wayne Medical Society
Referred to: Reference Committee 3
Action: Adopted as amended

Whereas, Indiana is now seeing an increase in managed care agreements; and

Whereas, capitation, which is inherent in many of these agreements, limits the physician's ability to provide care which meets the patients' needs in some cases; and

Whereas, physicians acting as patient advocates, who speak out in objection to the effect of those limits on patient care may be subject to retaliation; and

resolutions

Whereas, a physician may be deselected from a managed care arrangement solely for being a patient advocate; and

Whereas, the state of California has already enacted protection for physicians as patient advocates; therefore be it

RESOLVED, That the ISMA petition the Indiana State Legislature to enact legislation which would provide relief to physicians subject to retaliation for acting as patient care advocates.

RESOLUTION 95-32 **Physician-specific data release**

Introduced by: Vanderburgh County Medical Society
Referred to: Reference Committee 1
Action: Adopted

Whereas, business coalitions exist in at least Fort Wayne, Indianapolis, Evansville and northern Indiana; and

Whereas, these business coalitions are linked to the Mid West Business Coalition out of Illinois; and

Whereas, these coalitions have as one of their primary goals the release of physician-specific outcomes data to employers and their employees (our patients); and

Whereas, these discussions will occur in each community at different times and under different circumstances; and

Whereas, the mechanisms to measure this data are inaccurate and prone to problems; and

Whereas, there is some question as to the protection of physician-specific outcomes data as peer review information and therefore not subject to public release under existing Indiana law; and

Whereas, the Health Care Quality Improvement Act of 1985 addresses the release of physician-specific data; and

Whereas, other areas have successfully avoided the release of physician-specific outcomes data; therefore be it

RESOLVED, that the ISMA legal staff research and disseminate immediately to county medical society executives with follow-up release to physicians the current legal opinions and activities of other states on the issue of physician-specific data release; and be it further

RESOLVED, that the ISMA formulate a position based on this information.

RESOLUTION 95-33 **Modification of the Indiana peer review statute**

Introduced by: Vanderburgh County Medical Society
Referred to: Reference Committee 3
Action: Referred to Board of Trustees

Whereas, the Indiana Peer Review Statutes (I.C. 34-4-12.6) provide immunity to individuals who participate in peer review activities and who meet the statutory requirements; and

Whereas, Physician's Assistance Committees (PACs) or impaired Physicians Committees are generally organized under the Indiana Peer Review Statutes; and

Whereas, in some instances, individuals may come forward to the PAC with information regarding a potentially impaired physician if they can remain anonymous; and

Whereas, Section 34-4-12.6-2 (d) recognizes that a provider "under investigation" has access to his/her accumulated records regarding the provider's personal practice from the peer review committee, in this case the PAC; and

Whereas, this provision has the capability to void the anonymity of the informant and therefore greatly diminish the likelihood of individuals coming forward without the protection of their identity and, in some cases, endanger that individual; therefore be it

RESOLVED, that ISMA draft legislation that may amend the Peer Review Statute to recognize that, in special circumstances such as a Physician's Assistance Committee or an Impaired Physician's Committee, the identity of an informant may be protected under the statute; and be it further

RESOLVED, that ISMA review the entire statute to ensure that language, particularly the term "under investigation," is reasonable in the context of Physician Assistance Committees and their important activities in early identification of physicians impaired by psychiatric illness, psychoactive substance abuse/dependency or physical illness.

RESOLUTION 95-34 **Reaffirmation of the provisions of the Patient Protection Act**
Introduced by: Vanderburgh County Medical Society
Referred to: Reference Committee 1
Action: Adopted

Whereas, the ISMA House of Delegates adopted resolution 94-15 in 1994, which called for the elements of the AMA's Patient Protection Act to become a legislative initiative of the ISMA in the 1995 Indiana legislature to protect the rights and choices of Indiana patients and their physicians; and

Whereas, elements of the AMA's Patient Protection Act were in fact introduced as bills in the 1995 legislative session; and

Whereas, this legislation did not pass out of committee; and

Whereas, the need for statutory protections of the rights and choices of Indiana patients has certainly increased in the past year; therefore be it

RESOLVED, That the ISMA reaffirm its support of the concepts and elements of the Patient Protection Act and once again mount a legislative initiative to cause its passage in the 1996 legislative session.

RESOLUTION 95-35 **Ameritech's Caller ID**
Introduced by: Vanderburgh County Medical Society
Referred to: Reference Committee 4
Action: Adopted as amended

Whereas, Ameritech offers for a fee a new service to all customers called "Caller ID" which allows people to know who is calling them before they answer their telephone; and

Whereas, the identification of the caller is accomplished by a small device that is placed between the telephone and wall jack which is capable of displaying the phone number and name of the person calling before the telephone is answered; and

Whereas, physicians frequently communicate with patients in on-call situations from either their home or their private office numbers; and

Whereas, it is not inconceivable that a narcotics-seeking patient might phone through the answering service to an on-call physician who might return that patient's call only to have his/her private phone number forever available to this patient; and

Whereas, many people pay for the extra privacy of an unlisted and/or non-published number; and

Whereas, the Caller ID service not only negates these services and violates the privacy of those who pay for them but also enables those who have the Caller ID services to dial a three-character prefix and recall the last caller's number; and

Whereas, while Ameritech provides each customer with the option of dialing a three-character prefix prior to dialing the actual telephone number which then blocks the Caller ID function, this is at best an inconvenience and, in cases of some PBX type of telephone systems in offices or hospitals, is not possible; and

Whereas, Indiana is one of only a handful of states which does not have a provision for blocking Caller ID other than the three-character prefix; and

Whereas, the Federal Communications Commission has recently come to recognize the potential for use of Caller ID by an abusive spouse to track down the abused spouse or to at least have an easy mechanism to harass the abused spouse; therefore be it

RESOLVED, that ISMA contact Ameritech and all other telecommunications companies and with the force of its membership request that all customers be offered, at no charge, the option to block Caller ID.

RESOLUTION 95-36 **Provider representative**
Introduced by: Vanderburgh County Medical Society
Referred to: Reference Committee 4
Action: Adopted as amended

Whereas, large insurance conglomerates are purchasing smaller companies; and

Whereas, this is resulting in a consolidation of insurance companies who then have the ability to control large segments of the provider market by virtue of their market dominance; and

Whereas, this control is manifested in unreasonable requests for procedure justification as well as routine denial of care and denial of claims; and

Whereas, the physician is entrusted and charged with patient care responsibility and is the qualified patient advocate; and

Whereas, there is an insulation of the insurance carriers and no recourse for the physician and his/her patient in these instances; and

Whereas, the commissioner of insurance of the state of Indiana only responds to patient or insurance company inquiries, and not to physician concerns as

the primary care giver, about denials of care; therefore be it

RESOLVED, That the ISMA encourage the commissioner of insurance of the state of Indiana to establish and fund a provider representative within that office who would oversee and be responsible to providers for review and adjudication of unreasonable practices by insurers including, but not limited to, unreasonable requests for procedure justification and denials of care or claims.

RESOLUTION 95-37 **Injuries from fireworks**
Introduced by: Boone County Medical Society
Referred to: Reference Committee 2
Action: Adopted as amended

Whereas, public fireworks displays are prepared and executed by persons trained in safe methods; and

Whereas, each year more than 3,000 children suffer eye damages from fireworks. The typical victim is male, age 13-15; and

Whereas, bottle rockets cause 83% of eye injuries. Bottle rockets can shoot in erratic and unpredictable directions. Other rockets can be even more dangerous. Smaller bottle rockets can be propelled at 35-75 mph. Large ones take off at 200 mph; and

Whereas, class C fireworks, including bottle rockets, are legal in 30 states. In states that have banned fireworks, people are still hurt by "bootleg" fireworks brought from other states; and

Whereas, only a nationwide prohibition and strict enforcement will reduce the tragic toll; and

Whereas, the fireworks lobby is interested in legislation to liberalize sales of fireworks without risk or responsibility for fireworks injuries; and

Whereas, some state legislatures have established legislation to limit fireworks injuries; therefore be it

RESOLVED, That legislation be supported to curtail or eliminate sales of fireworks; and be it further

RESOLVED, That the ISMA consider a resolution to submit to the AMA to seek similar federal legislation; and be it further

RESOLVED, That the ISMA support, through any means possible, an education program at the grade school and high school level, that addresses the dangers of fireworks and especially the ocular injuries caused by bottle rockets.

RESOLUTION 95-38 **Medicaid reform**
Introduced by: Indiana Chapter of the American College of Emergency Physicians
Referred to: Reference Committee 4
Action: Adopted

Whereas, 42 U.S.C. 1935dd mandates a medical screening exam for all patients presenting to any emergency department requesting care; and

Whereas, the screening exam must also avail itself to all hospital ancillary services including lab and x-ray; and

Whereas, Indiana's Office of Medicaid Policy and Planning has established a new Risk Based Managed Care program, which refuses payment for emergency physicians when the visit is deemed "routine"; and

Whereas, these policies will result in decreased access to emergency departments for Medicaid patients and will offer no reimbursement mechanism for emergency physicians; therefore be it

RESOLVED, That the Indiana State Medical Association will work with the governor's office and the Indiana General Assembly to ensure access to the emergency department for all Medicaid patients and ensure a mechanism of reimbursement for emergency physicians for all patients evaluated in the emergency department.

RESOLUTION 95-39 **Helmet legislation**
Introduced by: Indiana Chapter American College of Emergency Physicians
Referred to: Reference Committee 2
Action: Withdrawn by author

Whereas, Section 153 of the Intermodal Surface Transportation Efficiency Act of 1991 (ISTEA), a program created several years ago to encourage states to enact a safety belt and all-rider motorcycle helmet use law that is unique in that it does not sanction states, and therefore our state will not lose a penny of federal funds; and

Whereas, Section 153 is a priority of the health, safety and business community and hundreds of groups representing hundreds of thousands of Americans support this program and have worked for its implementation; and

Whereas, it is our opinion that our state's resources would be better spent helping our own state comply

with Section 153, rather than attempting to undermine this program; and

Whereas, in a poll conducted by *The Indianapolis Star*, over 70% of Hoosiers support a mandatory helmet law; and

Whereas, at a time when everyone is concerned with rising health care costs, a basic injury prevention program that will help lessen the burdens of our emergency departments, hospitals, rehabilitation centers and welfare programs should be a priority; and

Whereas, taxpayers pick up much of the bill for people who are injured in motor vehicle crashes and pay up to 80% of the cost for injured motorcyclists; and

Whereas, mandatory safety belt and helmet use is proven to prevent injuries and deaths. According to NHTSA, with 100% motorcycle helmet use, our state would have saved 18 lives and $17.9 million in 1992 alone, and 210 lives and $228.1 million between 1984 and 1994; therefore be it

RESOLVED, That the state of Indiana needs an all-rider motorcycle helmet use law, and that the ISMA support Section 153 and seek enactment of a new state all-rider motorcycle helmet law.

RESOLUTION 95-40 **Health care worker violence**

Introduced by: Indiana Chapter of the American College of Emergency Physicians

Referred to: Reference Committee 3

Action: Adopted as amended

Whereas, violence against health care workers has resulted in death and injury of emergency personnel, including three physicians in 1993 at USC Medical Center; and

Whereas, such incidents of violence are common (1992 survey of 103 California hospitals found that 58% of respondents reported injuries to staff, visitors or other patients that were related to acts of violence, and 41% of the time the weapon was a gun; and a 1991 survey of emergency nurses found that 67% have reported at least one assault during their careers); therefore be it

RESOLVED, That the Indiana State Medical Association work with the Indiana State Nurses Association and the Indiana Paramedics Association to support legislation calling for stiffer criminal penalties for physical assault of health care workers in the carrying out of their professional duties; and be it further

RESOLVED, That ISMA support educational efforts on the prevention of assault on health care workers.

RESOLUTION 95-41 **Poison control centers**

Introduced by: Indiana Chapter of the American College of Emergency Physicians

Referred to: Reference Committee 2

Action: Adopted

Whereas, there were over 1.5 million calls to Poison Control Centers in 1989 and estimates of actual poisonings were over twice that amount; and

Whereas, a majority of the poisonings reported were in children under the age of five, and 80-90% of child and adult poisonings result in hospital admissions; and

Whereas, Methodist Hospital of Indianapolis is currently the only poison control center operating in Indiana and it is severely financially strained; therefore be it

RESOLVED, That the Indiana State Medical Association support the concept of a statewide poison control system; and be it further

RESOLVED, That the ISMA advocate for adequate state funding for the poison control center.

RESOLUTION 95-42A **Electronic filing**

Introduced by: Delaware-Blackford County Medical Society and David Dersch, M.D.

Referred to: Reference Committee 4

Action: Adopted substitute Resolution 95-42A instead of 95-42 and 95-46

Whereas, medical practice parameters, including reimbursement procedures, are constantly changing to improve the quality of medical care, to increase the efficiency of third party reimbursements and to keep from unnecessarily having to increase the costs related to these; and

Whereas, Medicare and Medicaid programs discriminate by requiring special consent forms for sterilization and hysterectomy procedures to accompany reimbursement requests for these procedures; and

Whereas, this requirement makes it impossible to file electronically, thereby resulting in increased

inefficiency and increased cost to process reimbursements; and

Whereas, it would be more efficient and cost effective if all patient care reimbursement, whether the patient be insured by Medicaid, Medicare or private insurance companies, could be filed electronically; therefore be it

RESOLVED, That the ISMA work with Health and Human Services to change the Medicare and Medicaid reimbursement policy for patients who receive hysterectomy or sterilization procedures so that all reimbursements can be processed electronically; and be it further

RESOLVED, That the ISMA work with Medicaid to allow physicians to use the HCFA 1500 form for all Medicaid claims so they can file electronically.

RESOLUTION 95-43 **Pre-authorization consent forms**

Introduced by: Delaware-Blackford County Medical Society and David Dersch, M.D.

Referred to: Reference Committee 4

Action: Adopted as amended

Whereas, consent forms are necessary for the medical records; and

Whereas, Medicaid requires pre-authorization by written consent to the state agency; and

Whereas, private insurance companies pre-authorize by telephone using a confirmation code number; therefore be it

RESOLVED, That the ISMA work with Medicaid to make preauthorization available by phone.

RESOLUTION 95-44 **Insurance discrimination against victims of domestic violence**

Introduced by: Indiana Chapter, American College of Emergency Physicians and John McGoff, M.D.

Referred to: Reference Committee 3

Action: Adopted

Whereas, Domestic violence and abuse is the single most common cause of injury to women; and

Whereas, The lack of appropriate resources has resulted in inadequate medical, social and legal services for victims of domestic violence and abuse; and

Whereas, A recent congressional study revealed that half of all major insurance companies are known to deny health, life and other types of insurance coverage to victims of domestic violence and abuse because having a history of abuse makes the victims a bad insurance risk;

Whereas, The fear of denial of insurance coverage may discourage victims of domestic violence and abuse from reporting the abuse to their doctors and to law enforcement agencies; and

Whereas, At least 16 states now prohibit insurance discrimination against victims of domestic violence and abuse; therefore be it

RESOLVED, That ISMA oppose the denial of insurance coverage to victims of domestic violence and abuse and seek and support state legislation to prohibit such discrimination.

RESOLUTION 95-45 **Regulation of medicine**

Introduced by: Indiana Roentgen Society Michael A. Kinzer, M.D., President

Referred to: Reference Committee 3

Action: Referred to Board of Trustees

Whereas, technological forces are converging to transform telemedicine into a permanent, useful and affordable tool for physicians and health care networks, particularly in rural and underserved areas; and

Whereas, patients are entitled to receive the highest quality of medical care from their physicians, no matter if that care is rendered face to face or via telemedicine; and

Whereas, a physician is required to hold an Indiana license in order to practice medicine in this state and telemedicine involves this practice; and

Whereas, the state of Indiana has no legal mechanism by which to regulate non-resident physicians who are practicing telemedicine on patients located in Indiana; and

Whereas, the ability of the state to discipline such practitioners is both necessary and desirable for the protection of the citizens of this state and for the public interest, health, welfare and safety; therefore be it

RESOLVED, That ISMA support legislation to regulate non-resident physicians who practice telemedicine on patients in this state.

RESOLUTION 95-46 **Use of HCFA 1500 form by**

Medicaid

Introduced by: Delaware-Blackford County Medical Society and David Dersch, M.D.
Referred to: Reference Committee 4
Action: Adopted substitute Resolution 95-42A in lieu of 95-46

Whereas, Medicaid agreed to the use of the HCFA form, and the Medicaid standards for information reporting do not conforrn to the HCFA 1500 form; and

Whereas, it is impossible to record data electronically using the information reporting form that Medicaid requires, thereby increasing processing costs and inefficiency; therefore be it

RESOLVED, That the ISMA work with Medicaid to allow physicians to use the HCFA 1500 form for all Medicaid claims so they can file electronically.

RESOLUTION 95-47A **Young Physician Society**

Introduced by: Marc Duerden, M.D. Young Physician Ad-Hoc Committee
Referred to: Reference Committee 4
Action: Adopted substitute Resolution 95-47A

Whereas, young physician organizations have been established to promote involvement of all physicians under the age of 40 or in the first five years of practice; and

Whereas, the American Medical Association has created a Young Physician Section and has encouraged all state societies to develop similar organizations; and

Whereas, active participation of the membership is crucial to the success of the Indiana State Medical Association and to its goals to enhance the leadership skills of its members and to increase member participation from different segments of the physician population; and

Whereas, the ISMA has created an ad hoc committee to evaluate ways to better serve the young physicians in Indiana; therefore be it

RESOLVED, That the ISMA create a component society of at least 50 new ISMA members which qualify as young physicians under 40 years of age and/or in the first five years of practice. This component society will have one vote in the ISMA House of Delegates.

RESOLUTION 95-48 **Medical liability coverage for jail and prison physicians**

Introduced by: Daniel H. Cannon, M.D., Floyd County
Referred to: Reference Committee 3
Action: Adopted as amended

Whereas, the attorney general's office has indicated it will no longer provide medical liability coverage for independent contractor physicians who treat inmates in prisons and jails in Indiana; and

Whereas, the medical liability companies in Indiana have stopped writing coverage for these physicians; therefore be it

RESOLVED, That the ISMA support legislation that will address civil liability coverage for physicians who provide care to jail and prison inmates.

RESOLUTION 95-49 **Tax-exempt hospitals competing against tax-paying health care providers**

Introduced by: District 5 Medical Society
Referred to: Reference Committee 3
Action: Referred to Board of Trustees for study and report back to House of Delegates

Whereas, tax-exempt hospitals throughout the state of Indiana and the nation are competing against tax-paying health care providers in the delivery of outpatient health care services; and

Whereas, this is unfair competition with the tax-exempt hospital having a 40-50% tax advantage over the tax-paying provider; and

Whereas, it is also unfair to taxpayers and health care consumers since tax-exempt hospitals could better use these extra funds to reduce the cost of health care to the general public instead of using them to build unneeded health care facilities that compete directly against private practitioners and hospitals who do pay taxes; and

Whereas, the day is long gone when hospitals were charitable institutions as they originally were at their tax-free inception in the late 1800s and early 1900s, when they did render charitable care, but now, with the inception of welfare and Medicaid, private insurance money and Medicare, they have as many or more financial resources as any health care provider and are no longer in need of their tax-exempt status; and

Whereas, they are abusing their tax-exempt status by using these county, state and federal moneys to

build ever bigger and bigger institutions, and to compete more and more with those who provide the tax moneys upon which they depend; therefore be it

RESOLVED, That the District 5 Medical Society go on record stating that they think every tax exempt hospital in the state of Indiana should pay state income tax and county tax; and be it further

RESOLVED, That they should also be paying federal income tax just as all private health care providers do; and be it further

RESOLVED, That the state of Indiana establish a certificate of need legislation for any hospital construction, in-patient or out-patient.

RESOLUTION 95-50 **ISMA/ Indiana Hospital Association joint venture**

Introduced by: ISMA Executive Committee
Referred to: Reference Committee 1
Action: Adopted as amended

Whereas, there currently exists business coalitions that have been requesting outcome, utilization and other kinds of information from physicians with increasing influence; and

Whereas, some state legislatures have mandated the collection of such information; and

Whereas, the Indiana State Department of Health is piloting a data collection project and will serve as a future source for some community health status information requested by purchasers through the Indiana Health Data Center; and

Whereas, the American Medical Association is aware of this national trend to collect physician specific data and has created guidelines for protecting physician and patient information while still maintaining the usefulness of such information; and

Whereas, the future of collecting health data without a state mandate is unclear and may soon be out of the hands of Indiana physicians; and

Whereas, the Indiana State Medical Association is currently in the position to influence and control the flow of health data on behalf of Indiana physicians if given the ability to do so during this small window of opportunity; and

Whereas, the Indiana State Medical Association should work for the best interests of Indiana physicians in the collection of health data; therefore be it

RESOLVED, That the Indiana State Medical Association work jointly with the Indiana Hospital Association in order to educate Indiana physicians and to create the means to collect health data; and be it further

RESOLVED, That the Indiana State Medical Association demand that the information be accurate and reliable prior to any dissemination of information; and be it further

RESOLVED, That the ISMA House of Delegates approve the funds to participate in this project with the Indiana Hospital Association for the betterment of Indiana physicians and the medical profession; and be it further

RESOLVED, That individual physicians have the opportunity to respond to data indicating that he or she is an outlier prior to release of this data to the public.

RESOLUTION 95-51 **Medical license fees**

Introduced by: Douglas W. Morrell, M.D., Rushville
Referred to: Reference Committee 3
Action: Adopted as amended

Whereas, the Indiana Medical Licensing Board has limited resources to investigate medical liability, fraud and abuse cases; and

Whereas, a strong and informed Indiana Medical Licensing Board would be of great benefit to both the medical community as well as the public at large; therefore be it

RESOLVED, That the medical license fees paid by all physicians be put in a dedicated fund for the exclusive use of the Medical Licensing Board so it will have adequate funds to perform its mission of protecting the public.

RESOLUTION 95-52 **Block grants**

Introduced by: Timothy N. Brown, M.D., Crawfordsville
Referred to: Reference Committee 1
Action: Adopted

Whereas, Congress is considering restructuring the Medicaid program to include payments to the states in the form of block grants; and

Whereas, physicians should provide input on the implementation of the block grants; therefore be it

RESOLVED, That the ISMA seek as public policy a partnership with physicians, public health officials, employers and state government to work on block grants for the care of the citizens of the state of Indiana;

and therefore be it further

RESOLVED, That the partnership also work to identify outcomes measures and establish reporting mechanisms for identifying benchmarks for attaining optimal patient health outcomes; and therefore be it further

RESOLVED, That incentive programs be established to encourage providers to achieve the benchmarks.

RESOLUTION 95-53 Resolution of appreciation to honor J. William Wright II, M.D.

Whereas, Dr. J. William Wright's insight and leadership in assisting the ISMA's legislative effort to enact the Indiana Medical Malpractice Act resulted in landmark tort reform that went into law in April 1975 and has lasted for two decades; and

Whereas, Dr. Wright has provided ongoing financial contributions and his personal efforts to preserve INCAP; and

Whereas, all Indiana physicians have experienced the loss of a physician leader and grassroots organizer whose efforts have benefited all patients in Indiana; therefore be it

RESOLVED, That this 1995 ISMA House of Delegates publicly acknowledge their grateful appreciation for the extensive contributions of J. William Wright II, M.D., which continue to provide benefit to all Indiana physicians and their patients.

RESOLUTION 95-54 Resolution of appreciation to honor Walter J. Daly, M.D.

Walter J. Daly, M.D., is a Hoosier from Delaware County that has served his state with distinction, perseverance and prudence.

He attended Indiana University at Bloomington and was a physiology assistant to Paul Harmon, professor and chairman of the department. He graduated at the top of his class from Indiana University School of Medicine in 1955. He served an internship and residency in internal medicine at Long Hospital, and the Indiana University Medical Center in 1955, 1956, 1957, and 1959-60. He was a special post-doctoral fellow in pulmonary medicine from 1960-62 with John Hickam, M.D., and was a captain in the U.S. Army from 1957-1959.

For 13 years prior to assuming the deanship, he was the James O. Ritchy Professor and chairman of the department of internal medicine. He served on the AMA residency review committee and the liaison committee with internal medicine. On Walter's watch as dean from 1983-1995, the school sustained and gained international leadership in education, research and service.

Walter Daly's understanding, candor and commitment have benefited each of us and people worldwide. For all of this, the members of the ISMA express their thanks and best wishes for his continued commitment to excellence.

RESOLUTION 95-55 Resolution of appreciation for Marvin E. Priddy, M.D.

Whereas, Marvin E. Priddy has faithfully and energetically served his profession at the national level as a delegate to the AMA for over 20 years; and

Whereas, Marvin E. Priddy, for 10 of those years, was elected by his fellow Hoosier delegates to the honorable and responsible position as chairman of the Indiana delegation; and

Whereas, Marvin E. Priddy has now found it necessary to retire from his position on the AMA delegation; therefore be it

RESOLVED, That this ISMA House of Delegates now assembled express its sincere appreciation for all of his efforts in the promotion and defense of the profession; and be it further

RESOLVED, That this resolution be presented to the AMA House of Delegates for their consideration. ⌟

ISMA Fifty Year Club

The Indiana State Medical Association honors 82 physicians this year in recognition of their 50 years of service as loyal and devoted practitioners of medicine. These new members of the Fifty Year Club will join the roster of other distinguished Hoosier physicians inducted into the Fifty Year Club since its inception in 1948.

The ISMA wishes to formally acknowledge the following physicians for their unselfish service to their patients and profession:

Dolores G. Adeva, M.D., Indianapolis
Joseph E. Alfanto, M.D., Chicago
Robert K. Allen, M.D., Indianapolis
Joseph W. Begley, M.D., Evansville
George H. Belshaw, M.D., Bozeman, Mont.
Edward J. Berman, M.D., Naples, Fla.
Donald P. Bixler, M.D., Anderson
Crist A. Blassaras, M.D., Anderson
Peter A. Blichert, M.D., Fort Wayne
James Bopp, M.D., Terre Haute
Harvey J. Brechtl, M.D., Mishawaka
Robert E. Bryan, M.D., Kendallville
George M. Buehler, M.D., Borden
Milton A. Butts, M.D., South Bend
Daniel H. Cannon, M.D., New Albany
Henry W. Conrad, M.D., Hamilton, Mo.
Stanton E. Cope, M.D., Clearwater, Fla.
Reuben A. Craig, M.D., Naples, Fla.
Theodore R. Crawford, M.D., Noblesville
William H. Davis, M.D., Crawfordsville
Frank C. Donaldson, M.D., Anderson
Edward G. Dovey, M.D., Summerlan Key, Fla.
Marion C. Drake, M.D., Elwood
Richard W. Dyke, M.D., Indianapolis
Martin E. Feferman, M.D., South Bend
James O. Futterknecht, M.D., Elkhart
Tierry F. Garcia, M.D., Indianapolis
Robert W. Gilmore, M.D., Michigan City
Russell E. Graf, M.D., Bowling Green, Ky.
Jack C. Greisen, M.D., Hammond
Harold R. Griffith, M.D., La Jolla, Calif.
James R. Guthrie, M.D., Richmond
John J. Hartman, M.D., Angola
Eugene L. Hendershot, M.D., Evansville
Ray A. Henn, M.D., Greenfield
Harland V. Hippensteel, M.D., Auburn
Paul R. Honan, M.D., Lebanon
James E. Hull, M.D., Lafayette
Harry L. Hunter, M.D., Bethesda, Md.
John H. Ivy, M.D., Elkhart
John F. Jackson, M.D., Kewadin, Mich.
Allen W. Jones, M.D., Indianapolis
Donald M. Kerr, M.D., Bedford
Harold King, M.D., Indianapolis
Paul J. Kirkhoff, M.D., Indianapolis
Bernard I. Levatin, M.D., Sarasota, Fla.
Charles K. Liddell, M.D., Michigan City
Frank P. Lloyd Sr., M.D., Indianapolis
Alfonso E. Lopez, M.D., Portland
James R. Mackenzie, M.D., Indianapolis
Rodolfo M. Madlang, M.D., Beverly Hills, Calif.
William M. Matthews, M.D., Culver
Bruce A. McArt, M.D., Elkhart
Bobby L. Moss, M.D., Indianapolis
Joseph F. Murphy, M.D., Lansing, Ill.
Robert F. Nagan, M.D., Indianapolis
Charles A. Novy, M.D., Garrett
E. Camille Parker, M.D., Logansport
Eudell G. Paul, M.D., Ely, Minn.
Stephen R. Phelps, M.D., South Bend
George C. Poolitsan, M.D., Bloomington
Bernard F. Poracky, M.D., Portage
Shirley G. Price, M.D., Elberfeld
Edsel S. Reed, M.D., Jeffersonville
Ordonio J. Reyes, M.D., Carmel
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Francis M. Sellers, M.D., South Bend
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Chen T. Sun, M.D., Hebron
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Tom W. Wachob, M.D., Kokomo
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Sleeping position and sudden infant death syndrome:

A review of the literature and the implications for infants in the United States

Catherine M. Bradshaw, M.D.
Chicago, Ill.

The incidence of sudden infant death syndrome (SIDS) in the United States is approximately 1.3 per 1,000 live births and has remained essentially unchanged in the past decade, despite an overall decrease in infant mortality. The incidence of SIDS in other parts of the developed world had also remained constant until recently when several countries began adopting the supine or lateral sleeping position for their infants.[1] A number of studies from various countries have suggested a causal relationship between the prone sleeping position and SIDS. Many believe that advocating the non-prone sleeping position for healthy infants is a simple and effective way of saving the lives of at least a small number of infants. In 1992, the American Academy of Pediatrics officially recommended that healthy infants, excluding those with gastroesophageal reflux and those with certain upper airway anomalies, be put down to sleep on their sides or backs.[18] However, the studies upon which this recommendation is based were conducted in countries whose infant care practices differ from those in the United States, and there is some question of whether the findings of these studies will be transferable to the United States. Because of this question, the AAP recommendation has been criticized by those expressing concern over the possible negative effects such a recommendation may have. The purpose of this paper, therefore, is to examine the available evidence supporting such a recommendation, discuss the applicability of these findings to infant care practices in the United States and determine whether the beneficial effect of avoiding the prone position is likely to outweigh the possible harmful effects.

Epidemiological studies

One of the first suggestions that the prone position might be associated with an increased risk of SIDS was the observation that the incidence of SIDS is extremely low in Hong Kong, where nearly all babies are put to sleep swaddled in the supine position. The rate in Hong Kong is 0.04 per 1,000 live births versus two to three per 1,000 in Western countries.[2] Some postulated that this phenomenon may be attributable to the fact that, due to crowded living conditions, babies in Hong Kong are hardly ever left alone.[3] Still, this finding has prompted others to investigate further the relationship of the prone sleeping position to SIDS.

Retrospective studies

Several retrospective case-control studies from Tasmania, England, New Zealand, the Netherlands and Hong Kong, among others, have shown a significant association between the prone sleeping position and SIDS. A few of these studies are recounted here.

Tasmania – A 1980-1986 study in Tasmania of 167 cases of SIDS compared with 334 controls showed 59% of cases sleeping prone versus 43% of controls, a relative risk of 1.9 for the prone versus the lateral position. This relative risk, as will be discussed later, is lower than that found by later studies comparing the prone to the supine position. Very few babies in this group slept supine, so the risk for supine sleeping could not be calculated. Controls in this study were matched for age, hospital of birth, season of birth and sex.[4] A 1989-1991 study in Tasmania showed the unadjusted odds ratio for "usually" sleeping prone to be 5.04. After adjusting for maternal age and birth weight, the odds ratio was 13.91. Breast-feeding and sex were found not to be confounders of this relationship.[5]

England – A 1990 study from the English counties of Avon and Somerset looked at 67 cases of

SIDS and 134 controls matched for age, date and neighborhood and found a relative risk of 8.8 for "put to sleep prone" versus put to sleep on the side or back.[6]

New Zealand – The incidence of SIDS in New Zealand in 1986-87 was 7.3 per 1,000, one of the highest in the world. In a 1986-87 study of SIDS in southern New Zealand, 81% of 49 cases were found prone, compared to a general prevalence of prone sleeping estimated to be 49%. Seventy-nine percent of the SIDS babies found prone, or 71% of all cases, were found with their faces down or their heads covered with bedding.[7] A 1991 study in New Zealand of 128 cases and 503 controls showed an unadjusted odds ratio of 5.74 for "last placed" prone and a population attributable risk of 52.1% after controlling for breast-feeding and maternal smoking. The controls for this study were randomly selected from all births and matched for age distribution only.[8]

The Netherlands – A 1989 study from the Netherlands of SIDS cases involving primarily normal birth weight infants showed a relative risk of 9.3 for "usually placed prone" and 4.9 for "last placed prone," after correction for prematurity, age, socioeconomic status and local traditions. The relative risks were reportedly lower before correction for these variables.[9]

Hong Kong – A small 1986-87 study in Hong Kong of 16 cases and 32 controls matched for sex and age showed 44% of cases versus 7% of controls with prone as the "usual" sleeping position, giving an odds ratio of 11.67. There was no difference between cases and controls with regards to maternal smoking, socioeconomic status, birth weight, gestational age, sleeping with parents or sleeping in parents' room. The incidence of SIDS was 0.3 per 1,000. This was higher than the 0.04 per 1,000 reported previously, probably due to a change in diagnostic criteria.[10]

Several factors must be taken into consideration when interpreting these case-control studies. The studies differ slightly in the age ranges that they allowed for SIDS cases, with a low-cutoff age ranging from birth to one month and a high-cutoff age ranging from 40 weeks to one year, but this variation does not detract from the strength of the studies taken as a whole.

Another consideration is that since common health care practices may be taught to all parents at a given hospital or shared by all parents in a local community, selecting controls from the same hospital or the same neighborhood would decrease the likelihood of detecting a statistically significant difference between infants with different sleeping habits, thus minimizing the degree of association found. There are a few other difficulties, however, that have caused some to question the actual conclusions of the studies and therefore must be addressed. These are: 1) recall bias; 2) variation in the means of identifying sleeping position; and 3) inconsistency in the degree of adjustment for potential confounders.

Recall bias – There was some question of whether recall bias may have influenced the results of these case-control studies. Before 1991 or so, parents would not have known that the prone position was a risk factor for SIDS and therefore would not have been biased to underreport or overreport.[11] However, parental reports of "position found" may be biased by the questioner, and parents may be influenced by traditional advice recommending the prone position.[12] Others hypothesized that a child's death may cause parents to report events that would be forgotten or unreported by parents of healthy children, so that differences in the accuracy of recall and of reporting would increase the chance that harmless events become identified as risk factors for a disease. To investigate this, parents of SIDS cases and of controls were interviewed, and the reported data were compared to actual data from the medical record. Results showed no difference in the tendency of either group to over- or under-report any of several conditions associated with SIDS and strongly refuted the idea that recall bias could account for the association between prone position and SIDS.[13]

Identification of sleeping position – Sleeping position in each of these studies was identified in one or all of three ways: 1) by the usual sleeping position; 2) by the position in which the infant was last placed; and 3) by the position in which the infant was found dead. Only studies reporting "usual" position consistently define the sleeping position similarly for both cases and controls.[14] Studies utilizing the last two means identify the sleeping position of controls by either: 1) the usual position; 2) the position in which the infant was placed for its previous sleep; or 3) the position in which the infant was found at an assigned time of day. Only methods (2) and (3) provide a comparable means of defining sleeping position for both cases and controls. One early study done in Northern Ireland in 1970 found no significant difference between the usual sleeping position reported by parents and the position in which infants were found dead.[15] However, in one Tasma-

nian study, the usual sleeping position corresponded to the position found in 96% of controls but only 74% of cases, so it is even possible that the infants who died did not actually die in the position assigned to them.[16] Beal and Finch found that odds ratios were larger, in general, for studies based on position found or position last placed,[14] so those considering usual position may tend to underestimate the real risk.[17] The difference, if any, between the various ways of recording sleeping position may account in part for the wide discrepancy in odds ratios and relative risks reported by the various studies. To avoid this uncertainty, the AAP, in making its recommendation against the prone sleeping position, chose to consider only those studies based on usual sleeping position.[18]

Adjustment for confounders – One must consider whether one or several confounding variables are creating an apparent association between the prone position and SIDS that is not real. Maternal smoking, lack of breast-feeding, gestational age, birth weight, socioeconomic status, ethnicity and sex are known risk factors for SIDS and therefore potential confounders. In at least two studies, correction for some of these variables actually increased the association rather than diminishing it.[9,19] Nonetheless, there is still the possibility that prone sleeping is not in itself a risk factor but is actually a marker for some other risk factor that is as yet unknown.[20] For example, there may be an unknown condition that predisposes a baby to SIDS and also causes the baby to prefer to sleep in the prone position. This question bears consideration and demands that one consider the plausibility of the pathophysiologic mechanisms that explain how the prone position may predispose an infant to sudden death. These mechanisms will be discussed later in this article.

In order to derive a useable synthesis of the variety of studies that had been done, Beal and Finch performed a logit estimate of common odds ratio using all studies up to July 1991 whose controls were broadly representative of the population from which cases were selected and for which "usual sleeping position" was available, including studies from Tasmania, New Zealand, Europe and Hong Kong, among others. The calculated common odds ratio was 2.72 (95% CI [2.27-3.26]).[14] It has also been noted that no published report has suggested a decreased incidence of SIDS associated with the prone position.[18] Some still raise the concern that the prone position itself is not a cause of SIDS but rather the factors that determine whether parents place their baby prone are themselves causes of SIDS. Only a prospective randomized trial could completely remove this doubt, but at this point in our knowledge, such a trial would probably be unethical.

Prospective studies

A prospective cohort study has been done in Tasmania that supports the conclusions suggested by the numerous retrospective, case-control studies. This study followed a large cohort of infants judged to be at high risk for SIDS (based on a number of criteria including maternal age, birth weight, season of birth, sex, duration of second stage of labor and breastfeeding), which comprised approximately one-fifth of all births over that period of time. The incidence of SIDS among the cohort was 7.4 per 1,000 for the cohort compared to 3.5 per 1,000 for the general population.[5] After controlling for birth weight and maternal age, the odds ratio for the prone position as the "usual" sleeping position was 3.92 (95% CI [1.37-11.24]). The population attributable risk for the prone position was 66% for exposed infants in the cohort and 38% for the entire cohort.[19] Although the applicability to the general population of this study limited to high-risk infants is uncertain, the fact that the association derived from prospective data was similar to that found in the same population using retrospective data adds weight to the conclusions drawn by the retrospective studies.

Interventional studies

In addition to case-control studies and one prospective study, there are also several interventional studies from the Netherlands, England, South Australia and New Zealand, among others, that strongly support the association between the prone sleeping position and SIDS.

The Netherlands – In the Netherlands, the non-prone position for babies was officially recommended in the fall of 1987. The incidence of SIDS at that time was 1-1.5 per 1,000. Prevalence of the prone position fell from 55% to 65% in 1987 to 15% in 1990, and by 1988 the incidence of SIDS had fallen by 37%. This was the first major drop in the incidence of SIDS ever reported in the Western world. There were no reciprocal increases in related causes of death. Whether there were changes in the prevalence of other risk factors is not known except that the prevalence of maternal smoking fell from 58% in 1975 to

Frank Ramsey, M.D., Writing Award winner focuses on SIDS

Catherine M. Bradshaw, M.D., a family practice resident at Cook County Hospital in Chicago, is the 1995 recipient of the Frank B. Ramsey, M.D., Medical Writing Award. Her paper, titled "Sleeping position and sudden infant death syndrome: A review of the literature and the implications for infants in the United States," is published here.

The award honors the memory of Frank B. Ramsey, M.D., who served as editor of *Indiana Medicine* for 41 years and was editor emeritus at the time of his death in 1993. This award, first given in 1994, is presented annually to a student from the Indiana University School of Medicine. The editorial board of *Indiana Medicine*, in association with the dean's office at the Indiana University School of Medicine, selects an outstanding medical or scientific paper written by a student. The winning paper is published in *Indiana Medicine*, and the author receives $500.

Dr. Bradshaw, a native of Indianapolis, earned her bachelor's degree at the University of Notre Dame. While attending the IU School of Medicine, she received several honors, including the Marcus Ravdin Medal for the highest scholastic achievement in her graduating class, the John H. Edwards Fellowship, the Distinguished Student/AMA Scholarship and the Department of Family Medicine Award. She graduated from the IU School of Medicine in 1995. ❑

Dr. Bradshaw

35% in 1989.[21]

England – In Avon County, England, a public campaign to promote the non-prone position resulted in a change in the prevalence of the prone position from 58% in 1987-89 to 28% in 1990-91. The incidence of SIDS in 1987-89 was 3.5 per 1,000. Based on the previously-calculated relative risk for the prone position, the rate was predicted to fall to 2.0 per 1,000 and actually fell to 1.7 per 1,000.[22]

Australia – In South Australia, after media publicity in January of 1988 about the risk of the prone position, there was a 30% decrease in the prevalence of prone sleeping and a 50% decrease in the number of SIDS cases.[23]

New Zealand – In 1989, a campaign was initiated in southern New Zealand that advocated side or back sleeping, smoking cessation, breastfeeding and avoidance of overheating. In New Zealand the population attributable risk for the prone position had been calculated to be 52%. Between 1987 and 1990, the SIDS rate in New Zealand fell from 4 to 3.1 per 1,000, while the prevalence of the prone position fell from 40% to 20.5%. Total infant mortality also fell by 24%, suggesting that the fall in SIDS was not due to a shift in reporting. There was also no change in the prevalence of breastfeeding and only a slight decrease in the prevalence of maternal smoking (from 33.2% to 28.4%).[24] In southern New Zealand, the incidence of SIDS dropped from 6.3 per 1,000 in 1979-84 to 2.3 per 1,000 in 1990, while prone sleeping dropped from 42% to 2.4% and the prevalence of the lateral position increased to 96%. There was no significant change in the prevalence of maternal smoking or of breastfeeding. Of note is the fact that the calculated odds ratio for prone sleeping did not change, even with the large change in the prevalence of the prone position.[23]

Unconfirmed reports from other countries have also suggested decreases in the incidence of SIDS after publicity about the association between the prone position and SIDS.[25] Scotland, however, has had no interventional campaign aimed at discouraging the prone position but has also seen a fall in the incidence of SIDS in recent years, from 2.24 to 1.30 per 1,000 from 1989 to 1991.[12] Some have taken

this as evidence that the decreases in the incidence of SIDS seen above may be secondary to effects other than the decrease in prone sleeping. Indeed, many English health regions have seen a decrease in SIDS without any campaign to discourage the prone position.[26] However, it is more likely that media campaigns initiated in one part of England, such as in Avon County, have influenced child care practices in other parts of the United Kingdom. For example, it is known that although the Isle of Mann is a relatively isolated community, the 1991 prevalence of the prone position on the Isle of Mann was identical to that in Avon County in 1991 following the media campaign in Avon.[27]

A number of factors could confound the results of these interventional studies: overall postneonatal mortality, prevalence of low-birth-weight infants, extent of prenatal drug exposure, incidence of respiratory tract infections, extent of anemia and smoking during pregnancy, increases in unreported infant mortality, diagnostic transfers and changes in coding practices for death certificates.[28] Since different groups of parents take up new child rearing habits at different rates, it may also be possible that there is a greater conversion rate to the supine position in infants at a lower intrinsic risk for SIDS, leaving the prone group with a preponderance of high-risk infants. Lower-income, less educated parents, whose babies are known to be at higher risk for SIDS, may be slow to adopt new recommendations for non-prone sleeping.[3]

Because of these uncertainties, a committee of experts met in Bethesda, Md., in January 1994 to evaluate the trends in postneonatal mortality and SIDS from 1980-1992 for Australia, Britain, New Zealand, the Netherlands, Norway, Sweden and the United States. This committee came to several conclusions: 1) In all countries in which the prevalence of the prone position had decreased rapidly, the incidence of SIDS decreased approximately 50%. 2) This decrease was not due to a change in reporting, since there were no reciprocal increases in other causes of death. 3) These low SIDS rates have been sustained as long as two to three years so far in New Zealand, Avon and Tasmania. 4) There has been no significant change in the prevalence of maternal smoking or of breast-feeding in these countries, even though these behaviors were also targeted by some of the interventional campaigns. 5) There have been so far no reported adverse effects of either the side or supine position in these countries.[1]

The lateral position and biological gradient

A.B. Hill described eight criteria by which a factor could be identified as a causative agent in a disease process. One of these criteria was biological gradient, or the observation that the degree of exposure to the factor influences the degree of disease seen.[29] This phenomenon can be seen with regard to the prone position and SIDS in at least two different ways. A study in the Netherlands in 1991 calculated that the relative risk of a baby "sometimes" being placed prone was less than that of "always" being placed prone (odds ratios 2.2 and 4.6, respectively).[30] In addition, the lateral sleeping position and its relationship to SIDS also support the idea of biological gradient.

The lateral position has been found to be unstable for babies in the SIDS age range. In one study, half of 104 12-week-old infants placed on their sides turned supine by morning.[25] In another survey of 406 infants age 2 weeks to 8 months, 65% of infants placed on their side were found supine and 4% were found prone.[31] Investigators in Avon County, England, estimated that up to 40% of infants put on their sides will roll to a different position, most to front and <1% to back.[22] A U.S. survey of 2- to 4-month-old infants showed that 50% of those placed on their side would roll to the back and 10% to the stomach.[1] Clearly, the lateral position can be thought of as an intermediate between the prone and the supine position. Accordingly, the lateral position is associated with a risk of SIDS that falls between that of the other positions. In a New Zealand study, the lateral position increased the risk approximately two-fold, while the prone position increased the risk by about 7.[11,32] In a South Australian study, of the 20 SIDS cases that had been last placed on their sides, 14 were found prone. Similar observations have reportedly been made in New Zealand and in England.[25] The lateral position, in other words, may carry risk because of the small chance that the infant will roll to the prone position.

Biological plausibility

Another of Hill's criteria for causation is biological plausibility.[29] In order for the prone position to be a causative factor in the etiology of SIDS and not merely a marker for another factor, there must be a reasonable pathophysiologic mechanism to explain the relationship between

the prone position and SIDS. Although no studies have clearly established a mechanism, postulated mechanisms include: airway obstruction, rebreathing of expired carbon dioxide, overheating, neck extension causing compression of cerebral vessels, decreased abdominal movement with respiration causing splinting of the diaphragm and decreased cardiac filling due to pressure on the thymus.[18,20,31] There are complex interactions between temperature regulation, respiratory patterns, chemoreceptor sensitivity and cardiac control, so an infant who inadvertently became face down while sleeping might suffocate if, for some reason, responsiveness to hypercarbia or hypoxia was deficient or gasping and arousal reflexes were too weak to re-establish air flow.[18] One author has even suggested that the prone position, by stimulating the upper airway or by nasal occlusion, triggers the dive reflex, which results in profound bradycardia and redistribution of blood flow to the lungs, brain and heart, leading to progressive hypoxia.[32]

That SIDS usually occurs in infants younger than six months (the age at which infants are able to roll over on their own) is consistent with the association between the prone position and SIDS. In the Netherlands, the fall in SIDS incidence after the interventional campaign was more marked for infants less than six months.[33] Inconsistent with this is the low incidence of SIDS in the first month of life, but this could be explained by other mechanisms such as a more effective gasp reflex in newborns[15] or the inability of the neonate to raise its head and place it face down.[25]

The following is a brief review of the three of the most investigated mechanisms by which the prone position might predispose to SIDS:

Airway obstruction – Two studies, one of 64 infants with a history of apnea[34] and one of 80 healthy 3-month-old infants[35] found that sleeping position did not significantly affect the rate or duration of central or obstructive apnea. These studies, however, have been challenged because they looked at only a small number of infants for only one night. During agonal gasping, such as after a prolonged episode of apnea, accessory muscles are used which tend to straighten the head, putting the prone infant face down and in a position to suffocate.[15] Unfortunately, there are not much data on whether prone infants who die of SIDS are actually found face down, since most studies do not distinguish between face-down and face-side.[28]

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Rebreathing of expired carbon dioxide – This hypothesis has some support from experiments using rabbit and mechanical models,[36,37] but a study of live infants found that infants sleeping prone do not develop lower transcutaneous carbon dioxide levels than infants sleeping supine.[38]

Hyperthermia – The overheating hypothesis has received much attention. A theoretical model that determined thermal balance in infants found that the head is the most important site of heat loss in the infant and that heat loss is diminished by turning the head face down. This study also found that the prone position decreases heat loss by increasing contact between the body surface and the underbedding, an effect that is increased with softer underbedding. They suggested that hyperthermia could result from a combination of increased metabolic rate and decreased heat loss, and that absolute or relative hyperthermia could explain many cases of SIDS, including why SIDS is so common in southern New Zealand (heavy dressing, prone position, soft bedding), so uncommon in Hong Kong (some heavy dressing, supine position), and so uncommon in Scandinavia (prone position but light dressing due to central heating). Cultural combinations of sleep position, clothing, bedding and central heating could explain why SIDS rates are so different in different countries.[39] At least two case-control studies have found that overheating and the prone position are independently associated with an increased risk of SIDS.[6,40] To date, very few studies have actually measured

body temperature and environmental temperature in investigating cases of SIDS.[28]

There are several postulated mechanisms for SIDS that go against its association with the prone position. Some of the pathophysiologic mechanisms believed to contribute to SIDS, such as apnea, hypoxemia and gastroesophageal reflux, have been shown by some studies to occur less frequently in the prone position.[16] Reports from New Zealand and the United States have suggested that SIDS might be caused by a defect in the control of airway muscles, which would be amplified in the supine position. The supine position may also be more likely to cause neck flexion, which increases upper airway resistance[28] and increases the susceptibility of the airway to collapse.[41] In addition, the effect of gravity on the tongue in the supine position would require more genioglossus tone to maintain airway patency, which may be dangerous in those infants whose decreased neuromuscular control puts them at risk for suffocation and asphyxia in the face down position. The supine position has also been suspected to cause an increased risk of adverse responses to pooled secretions in the posterior pharynx, such as obstruction, secondary apnea and aspiration.[28]

Effect modifiers and relevance of these findings to the United States

A matched analysis on data from Tasmania (80 cases and 333 controls) using the multiplicative model of interaction found that the association between the prone position and SIDS was increased by natural fiber mattresses (which are softer than other mattresses), swaddling, heated rooms and recent illness, although the effects of natural fiber mattresses and swaddling were only of borderline significance (p=.05 and p=.09, respectively). By themselves, natural fiber mattresses, swaddling, recent illness or heated rooms did not cause a significantly increased risk of SIDS. (Odds ratios ranged from 1.1 to 1.6 for these factors.) Since the presence of recent illness and heated rooms vary seasonally, these effect modifiers may explain why a decrease in prone sleeping causes a greater decrease in SIDS in the winter months as compared to the summer months.[42] Although the significance of these findings has been questioned because the large number of potential effect modifiers that were tested results in a large risk for an alpha error,[16] this study makes an important point: the strength of the association of the prone position and SIDS is at least partially dependent upon other factors. Differences in the prevalence of these or other effect modifiers may explain the variation among odds ratios measured in different countries. Since the combination of effect modifiers prevalent in the United States is different from that of other countries, it is unclear how much risk will be associated with prone sleeping in the United States. According to the only large case-control study of SIDS done in the United States, the odds ratio for the prone position here is only 1.3,[43] much lower than that found in other countries.

Soft bedding and overheating are the two factors most often quoted as mediating the association between the prone position and SIDS. These mediators are especially relevant to those who doubt the importance of the prone position as a cause of SIDS in the United States, since most babies in the United States sleep on firm, synthetic mattresses dressed appropriately for warm temperatures in houses with central heating. The data concerning each of these factors are discussed below:

Since the presence of recent illness and heated rooms vary seasonally, these effect modifiers may explain why a decrease in prone sleeping causes a greater decrease in SIDS in the winter months as compared to the summer months.[42]

Soft bedding – Some feel that the association between the prone position and SIDS would not exist in the absence of soft bedding. Half of the SIDS cases studied in southern New Zealand (odds ratio 5.74) were sleeping on sheepskins, and the other half probably slept on soft "woolen mattresses."[44] However, in Avon County, England (relative risk 8.8), very few infants were sleeping on soft bedding.[17]

Overheating – Others have suggested that the association between the prone position and

SIDS is dependent upon overwrapping and overheating. Indeed, most of the data showing a strong association between the prone position and SIDS comes from countries where the prevalence of central heating is limited and where babies are put to sleep with lots of bundling and bedding. These countries, even with their lower prevalence of prone sleeping, have a much higher incidence of SIDS than the United States (In southern New Zealand, the incidence is 6 to 7 per 1,000 with 40% prone, versus 1 to 2 per 1,000 in the United States with 70% to 80% sleeping prone.)[15] In Australia, where most households do not have central heating, the incidence of SIDS is higher during the colder months: In Tasmania, the wintertime incidence of SIDS is 6.3 per 1,000. In South Australia, the incidence is 4.2 per 1,000 in July and 0.7 per 1,000 in January. It is reasonable to assume that the prevalence of prone sleeping is the same in both summer and winter. In Sweden, where virtually all infants sleep in heated rooms with clothing and bedding appropriate for warm temperatures, there is less seasonal variation in SIDS.[16] Analysis of the trends of SIDS incidence in New Zealand, Australia, England and Wales has shown that, with a decrease in prone sleeping, the larger decrease in SIDS is occurring during winter months. What used to be a three-fold peak of SIDS in winter in these countries has now decreased to only 1.3-fold.[1] One might conclude from this that only those babies living in temperate climates without central heating need to avoid the prone position for sleep.[23] However, in Avon County, England (relative risk 8.8), over 80% of households have central heating.[17]

Some feel that the drop in SIDS seen in other countries will not be transferable to countries like the United States with lower initial rates. The incidence of SIDS in the United States is only 1.5 per 1,000, much lower than the 3.5 to 5.5 per 1,000 in England, Tasmania and New Zealand. However, according to the meeting of experts held in January 1994, the SIDS rates in some of the countries appear to be falling to levels below the U.S. rate. The provisional rates in Australia and Britain for 1992 were 1.1 and 0.7 per 1,000, respectively, down from 1.8 and 1.7 per 1,000 in 1988. The decreases in the prevalence of prone sleeping in these two countries were 31% to 3% and 59% to 2%, respectively.[1]

Drawbacks to recommending the non-prone position

The objective of this paper was to consider whether the evidence for the association between the prone sleeping position and SIDS is strong enough to merit a change in U.S. child care practices. What constitutes "strong enough" depends a great deal on the number of drawbacks inherent in making such a change. These drawbacks would include: 1) loss of inherent advantages to the prone position; 2) risks associated with the supine position; 3) difficulty with identifying those who should be exempted from such a recommendation; and 4) parental difficulty with following the recommendation.

Advantages to the prone position – The prone position, for one, is well known to decrease the incidence and degree of gastroesophageal reflux in infants. The American Academy of Pediatrics acknowledged this effect and exempted infants with known gastroesophageal reflux from their recommendation. The prone position has also been reported to improve pulmonary function in premature infants, but reports are contradictory with regard to full-term infants. Orthopaedic advantages to the prone position include prevention of scoliosis and possible prevention of restricted hip abduction. Prone as an awake position has been reported to improve motor development, but it is unknown whether the prone sleep position has this same effect.[3]

In spite of this, it seems that internationally the supine position is the most common position chosen by parents.[17] In 1990, the French language expert group for the study of SIDS concluded that there is "no physiologic justification" for using the prone sleeping position in normal infants.[25] In addition, the American Academy of Pediatrics, in making its 1992 recommendation of the non-prone position, stated that "no convincing long-term beneficial effects or positive influences on decreasing mortality have ever been shown for the prone position in the populations studied."[18]

Risks associated with the supine position – Contrary to popular belief, there is no evidence that aspiration is a more frequent complication in healthy infants lying supine compared to other positions. In countries where babies are routinely placed supine, SIDS and aspiration are both rare.[10] According to the meeting of experts in January 1994, countries with recent decreases in the prevalence of the prone position are not showing any adverse effects of supine sleeping, such as an increase in deaths due to aspiration or in apparent life-threatening events (ALTEs).[1] In the Netherlands, widespread adoption of the supine position in 1988 was

followed by a decrease rather than an increase in the incidence of lethal aspiration.[15] In Avon from 1984-91, the only lethal episodes of aspiration after the newborn period occurred in three neurologically impaired infants, all of whom were prone at the time.[17] From January 1985 to August 1989 in Adelaide, South Australia, only three infants who were found dead unexpectedly had died of aspiration, and all of these, too, were found prone. In fact, death from inhalation in the supine position is virtually unknown in the literature.[46]

Some have challenged that the absence of fatal aspiration is a very insensitive way of quantifying the potential hazards of supine sleeping, since clinical experience suggests that supine sleeping does indeed cause increased morbidity in infants susceptible to regurgitation. These authors suggest that supine sleeping may be causing increased morbidity forms that investigators are not identifying in the countries where studies are being done. However, latest results from two ongoing prospective studies in Avon County and Tasmania have shown no increase in doctor visits or reported episodes of illness for infants sleeping on their sides or backs as compared with infants sleeping on their stomachs before the start of the interventional campaign.[1]

Difficulty with the exemption of infants with gastroesophageal reflux – Although the AAP recommendation exempts infants with gastroesophageal reflux, it may be difficult to identify those infants. It is known that infants with apparent life-threatening events (ALTEs) secondary to regurgitation tend to have a greater degree of reflux during sleep than do infants with regurgitation without ALTEs. In fact, these infants may not have postprandial reflux at all and therefore may not be identified as having reflux until it is too late. Because of this, symptomatic reflux may not be a sensitive enough indicator to detect those infants who should sleep prone.[45]

At the other end of the spectrum, because regurgitation is so common among infants, it will be hard to know which cases of known regurgitation merit further workup to determine which should be excused from the AAP recommendation.[45] This dilemma will necessitate a greater extent (and greater cost) of evaluation for reflux disease. Depending on the definition of "significant" reflux, the majority of infants could conceivably be identified as having gastroesophageal reflux disease.[28] In one clinician's experience, patients describe regurgitation as a "problem" in 20% of "well" babies. According to this clinician, 7% of all infants will at some point see a physician for symptomatic reflux, 20% of these will undergo diagnostic testing, and one in 200 infants will require antireflux surgery. In low-birthweight infants, symptomatic reflux is even more common, with 3% to 10% of these having reflux-associated apnea, bradycardia or worsening of bronchopulmonary dysplasia.[47]

In truth, very little information is available on the potential adverse effects of the supine position. As the prevalence of supine sleeping increases following the AAP recommendation, physicians will have to watch for changes in such parameters as the incidence of illness, especially lower respiratory tract infections, and the frequency of complications of gastroesophageal reflux disease such as failure to thrive and aspiration pneumonia.[17] In some babies it may turn out that the risks of prone sleeping are counterbalanced by the risks of supine sleeping.

Parental difficulty with the non-prone position – Another potential negative effect of the AAP recommendation to avoid the prone position is the likelihood that parents may have difficulty implementing the recommendation. One study of 80 healthy 3-month-old infants found that the supine sleeping position was associated with a decrease in sleep duration and an increase in the number and duration of arousals, regardless of whether the infant was used to the prone or the supine position.[35] A 1960 study of 281 infants found that newborns in the supine position had more diaper rashes, more self-inflicted excoriation and more frequent crying. More that half of babies laying supine stopped crying when turned prone, but rarely did a prone baby stop crying when turned supine.[48] It is true that some babies seem naturally to prefer to sleep prone, and babies who will not stop crying or will not fall asleep in the supine position will be a problem for their families. Inevitably, the AAP recommendation will cause additional stress and anxiety for some parents.[12]

Conclusion

What has happened in the United States since the American Academy of Pediatrics made its official recommendation in 1992 of the non-prone position for healthy babies? As of January 1994, the prevalence of the prone position in the United States has dropped from 73% to 56%. In those states from which data on sleeping

position are available, no consistent pattern of change in SIDS rates has been seen. Some states have had no change and some have even reported an increase in SIDS despite a decrease in the prevalence of the prone position. However, King County, Wash., recorded a 52% decrease in SIDS from 1991 to 1992, which may be attributable to a newspaper editorial advocating non-prone sleeping. Unfortunately, the prevalence of the prone position in King County in 1991 and 1992 are not known. According to this same source, preliminary reports suggest that the incidence of SIDS in the United States may have decreased approximately 12% when comparing spring and summer months before and after the AAP recommendation.[49] All in all, that the United States has not seen anywhere near the 50% decreases in SIDS reported by other countries is very likely due to the fact that the prevalence of prone sleeping here has not decreased very much here in the last two years.

Considering all of the data recounted above, it is safe to conclude that the prone position is indeed a preventable factor in a long, complicated, enigmatic sequence of events that leads to sudden infant death. How much of a factor it plays in SIDS in the United States is still unknown, given the limited and inconclusive data available on the contributions of cultural factors such as soft bedding and central heating. However, the prone position is probably a significant enough factor to justify an intervention as simple as recommending the non-prone position for healthy babies. Case control studies are now being conducted in California, King County, Wash., Chicago and the Aberdeen Area of the Indian Health Service.[1]

Until data are available from these studies, I believe the best course of action is to recommend the supine or lateral sleeping position for healthy babies but still include reassurances for parents who have difficulty following the recommendation. In explaining the risks of prone sleeping to parents, we should emphasize that the risk for SIDS is low for most babies, regardless of sleeping position, and that this risk is only slightly increased by the prone position. All babies with significant reflux disease should be readily excused from the recommendation, and we must be careful to avoid giving parents the impression that their babies are falling "out of the frying pan and into the fire." For healthy babies, the supine position should be the first choice, but the lateral position is an ideal option for infants with mild or unconfirmed gastroesophageal reflux or those who do not sleep well in the supine position. If a baby does not sleep well in either the lateral or the supine position, the prone position is still a reasonable option to prevent undue stress and sleep deprivation for the family. We should avoid attributing more risk to the prone position than is actually there, but we cannot delay taking advantage of this new information that may help to save some babies' lives. ❑

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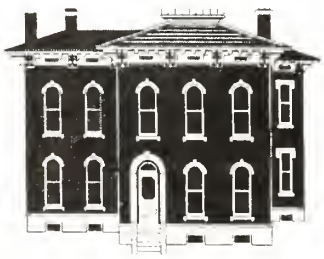

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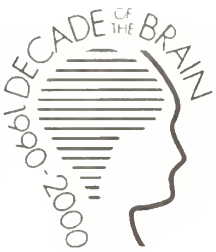

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ANATOMIC PATHOLOGY

alliance report

Valerie Gates
ISMA Alliance president

The ISMA Alliance annual convention was well attended by delegates representing 20 of our 24 organized counties. Twelve past ISMA Alliance presidents also attended. Activities for the convention included a luncheon ceremony to remember those Alliance members who had died during the past year, a workshop on grief with Dr. Clifford Kuhn, installation of the new officers, remarks by Sharon Scott, AMA Alliance president, a time to share ideas for membership, incoming and outgoing board meetings and the presentation by the county presidents of their county alliance programs and projects.

The hospitality room highlighted state and county alliance projects and programs. An AMA-ERF silent auction was held. The ISMA Alliance welcomed all society members to view the displays.

ISMA Alliance members would like to thank the ISMA and staff for all of their support. We are encouraged when we see all that has been accomplished for our physician families this year.

Alliance members are preparing a Medicine Day program and a Support Focus Workshop for the spring meeting. We plan to have all legislative phone trees active during the legislative session. We appreciate the updates from the staff of the ISMA Government Relations Department. The more informed we become, the more help we can provide our membership.

We look forward to our continued working relationship. ❑

Ann Wrenn, AMA Alliance secretary, of Bloomington, and Valerie Gates, ISMA Alliance president, of Valparaiso prepare to install next year's officers.

From left – Phyllis Walker, Bloomington; Laurel Weddle, Columbus; Fran Foster, Fort Wayne; Cheryl Haslitt, Muncie; Patty Lackey, Evansville; and Ann Wrenn, Bloomington, during the installation of officers.

cme calendar

Reid Hospital
Reid Hospital and Health Care Services in Richmond will present an evening seminar on "Occupational Health" Feb. 20.

For additional information, call Marie Hopper at (317) 983-3112.

St. Mary's Medical Center
St. Mary's Medical Center in Evansville will present the Annual G.I. Seminar on "Motility Disorders" Feb. 29 at 1 p.m.

For registration information, call (812) 485-4468.

St. Vincent Hospitals
St. Vincent Hospital and Health Services in Indianapolis will present these CME courses:

Mar. 15 – Emergency Room Physicians Seminar, location to be announced, Indianapolis.
Apr. 27-28 – 14th Annual Spring Seminar in Dermatopathology - "Compare Your Diagnoses with Bernie's," St. Vincent Hospital Cooling Auditorium, Indianapolis.
May 10 – Progress in Cardiology IX, Westin Hotel, Indianapolis.

For more information, call Beth Hartauer, (317) 338-3460.

Indiana University
The Indiana University School of Medicine will present the following CME courses:

Feb. 16 – Violence and Mental Illness.
Feb. 24-25 – Indiana Society of Anesthesiologists.
Mar. 1 – Prescription Writing and Controlled Substances.
Mar. 2 – Introduction to Neuropathology.
Mar. 15-16 – Thoracoscopy Workshop for Pulmonary Physicians, Indiana University School of Medicine Library, Indianapolis.
Apr. 13-14 – Dermatopathology.
Apr. 29 – 20th Annual del Regato Lecture.
May 10 – Hemostasis in Cardiothoracic Surgery.
May 17 – New Horizons in Medicine.
June 6-7 – ASCO.

All courses will be presented at the University Place Conference Center and Hotel in Indianapolis unless otherwise noted. For more information, call (317) 274-8353.

Washington University
Washington University School of Medicine will present these CME courses:

Mar. 13-15 – Annual Refresher Course and Update in General Surgery.
Mar. 21-22 – Clinical Pulmonary Update.
Mar. 30 – Cardiopulmonary Bypass & Coagulation Deficiencies for Surgeons.

All courses will be held at the Washington University Medical Center in St. Louis. For more information, call 1-800-325-9862.

University of Michigan
The University of Michigan Medical School will sponsor these CME courses:

Feb. 25-Mar. 2 – Radiology in the Mountains, Snowmass, Colo.
Feb. 28-Mar. 2 – Advances in the Management of Infectious Diseases: Winter Update, South Seas Plantation, Captiva Island, Fla.
Mar. 6 – Rapid Response to Myocardial Infarction, Laurel Manor Conference Center, Livonia, Mich.
Mar. 10-14 – Radiology in the Desert - Practical Aspects of Radiology and Imaging, Marriott's Camelback Inn Resort, Golf Club & Spa, Scottsdale, Ariz.
Mar. 12-16 – Family Practice 1996: 20th Annual Spring Review Course, Towsley Center, Ann Arbor, Mich.
Mar. 22 – Applied Clinical Informatics Symposium: Topics on Information Systems of Immediate Importance for the Practicing Clinician, Towsley Center, Ann Arbor, Mich.
Mar. 28-29 – Challenges and Changes in Obstetrics and Gynecology, Towsley Center, Ann Arbor, Mich.
Mar. 30 – Transvaginal Ultrasound Workshop, Towsley Center, Ann Arbor, Mich.

To register, call Vivian Woods at (313) 763-1400. ❑

news briefs

Three Indiana hospitals listed among top 100

Wishard Memorial Hospital in Indianapolis, St. Mary's Medical Center in Evansville and Deaconess Hospital in Evansville were judged among the country's best hospitals at delivering clinical care while making a profit, according to a recent analysis of nearly 4,000 acute care hospitals.

Modern Healthcare, a healthcare business news weekly magazine, announced the results of the study, which listed 100 hospitals judged on financial management, operations and clinical outcomes. The analysis was done by HCIA, a Baltimore-based healthcare information company, and Mercer, a New York-based human resources management consulting firm.

Wishard made the list for the third straight year and St. Mary's for the second time. This was the first time Deaconess was listed.

Free telephone service offers HIV information

HIV/AIDS Treatment Information Service (ATIS) is a free telephone reference service for health care providers and people living with HIV disease. Reference specialists answer questions about the latest treatment options, provide customized database searches and link callers to other HIV/AIDS information resources.

Through the service, callers can acquire copies of the latest federally approved treatment guidelines including:

- Recommendations for HIV Counseling and Voluntary Testing for Pregnant Women.
- Guidelines for the Prevention of Opportunistic Infections in Persons Infected with HIV.
- Study results concerning the Anti-HIV Therapy which Lowers Risk of AIDS, Death in Patients with Intermediate-Stage HIV Disease.

The treatment service recently developed the Glossary of HIV-AIDS-Related Terms to help people understand the technical terms related to HIV, its associated treatments and the medical management of related conditions.

The information service is offered through the CDC National AIDS Clearinghouse.

To receive a free copy of the glossary or obtain other information, call 1-800-HIV-0440 or send an e-mail to atis@cdcnac.aspensys.com.

Indiana Hand Center to develop network

The Indiana Hand Center, based in Indianapolis, has finalized an agreement with VIVRA, a national specialty health care company, to develop VIVRA-Orthopaedics, an orthopaedic specialist network.

VIVRA-Orthopaedics will focus on the development of networks of orthopaedists to establish provider-payer relationships for specialist care. The premise is to proactively present comprehensive orthopaedic management services to health insurance and workers' compensation payers and primary care physicians with risk contracts or gatekeeper responsibilities.

Hospital and health care mergers, affiliations

This list briefly summarizes recent news of mergers, acquisitions and affiliations of hospitals and other medical institutions. The information is reprinted *from Indiana Economic Log* with permission of NBD Bank, which compiles the list from newspaper stories.

- Healthcare Specialists of North Central Indiana is a new alliance of 30 physicians formed in Lafayette. Its primary goal is to provide statistics for doctors' contracts with insurance companies, and its secondary purpose is to assist new doctors coming into the area.
- Hobart-based Ancilla Systems plans to consolidate its Michiana Community Hospital in South Bend and its St. Joseph Hospital in Mishawaka and rename them St. Mary Community Hospital in South Bend and St. Joseph Community Hospital in Mishawaka. Ancilla Systems is creating a new regional health care organization called Ancilla Health Care, which includes the two hospitals; Edison Lakes Medical Center, Linden Vale Hospital and Healthy Family Center in Mishawaka; and 23 Medical Park Plaza and Pregnancy Clinic of Urbancare in South Bend.
- Wabash County Hospital has discontinued its previously announced plans to affiliate with the regional health care system that Parkview Memorial Hospital in Fort Wayne is attempting to establish with outlying community hospitals. ❑

obituaries

David H. Brewer, M.D.
Dr. Brewer, 64, former Taylor University Health Center physician, died Oct. 6, 1995, at his home in Hartford City.

He was a 1965 graduate of the University of Michigan Medical School.

Dr. Brewer established a general practice in Hartford City and Upland in 1987 and was on staff at the Blackford County Hospital. He was the Taylor University Health Center physician from 1988 to 1993. An ordained United Methodist minister, Dr. Brewer had served as a medical missionary in Nigeria and Haiti.

Clyde G. Culbertson, M.D.
Dr. Culbertson, 89, a medical researcher, educator and philanthropist, died Sept. 27, 1995, at the Four Seasons Health Care Center in Columbus, Ind.

He was a 1931 graduate of the Indiana University School of Medicine.

Dr. Culbertson had been professor and chair of the Department of Clinical Pathology at the IU Medical Center, director of the laboratory of hygiene at the Indiana State Board of Health, a founder and director of the Indianapolis American Red Cross Blood Donor Center and director of biological research at Eli Lilly & Co. He was instrumental in commercial development of the Salk polio vaccine, a safer rabies vaccine and the antibiotic erythromycin. He discovered that free living amebae could infect the brains of experimental animals and humans. One species of these amebae, *Acanthamoeba culbertsoni*, was named in his honor. After retiring from Lilly in 1970, he continted research on free living amebae in a Lilly laboratory in Wishard Hospital in Indianapolis and in a laboratory in his Nashville, Ind., home. He endowed the Culbertson Chair of Pathology Education in the IU School of Medicine to strengthen the education of medical students and provided leadership support for another endowed chair. Dr. Culbertson was a founding fellow of the College of American Pathologists and served as president of the American Society of Clinical Pathologists.

Bernard E. Edwards, M.D.
Dr. Edwards, 81, a South Bend anesthesiologist, died Oct. 21, 1995, at St. Joseph's Medical Center in South Bend.

He was a 1941 graduate of the Loma Linda University School of Medicine.

Dr. Edwards was a member of the American Society of Anesthesiologists, the International Anesthesia Research Society, the American and Midwest pain societies, the American Academy of Pain Medicine and the American Academy of Pain Management. He was a founding member of the International Association for the Study of Pain and a past president of the Indiana Academy of General Practice.

Harley F. Flannigan, M.D.
Dr. Flannigan, 86, a retired LaGrange family physician, died Oct. 19, 1995, at Parkview Memorial Hospital in Fort Wayne.

He was a 1931 graduate of the University of Tennessee Center for Health Sciences.

Dr. Flannigan moved to LaGrange from Hobart in 1937.

Emory D. Hamilton, M.D.
Dr. Hamilton, 81, a Fort Wayne anesthesiologist, died Oct. 5, 1995, at Woodview Health Care in Fort Wayne.

He was a 1940 graduate of the Indiana University School of Medicine and an Army veteran of World War II.

Dr. Hamilton had served as president of the St. Joseph Medical Center staff and of the Indiana Society of Anesthesiologists. He retired in 1982.

Maurice Kaufman, M.D.
Dr. Kaufman, 77, an Indianapolis internist, died Sept. 20, 1995.

He was a 1943 graduate of the Johns Hopkins University School of Medicine and served as a captain in the Army Medical Corps from 1944 to 1946.

Dr. Kaufman was in private practice in Bridgeport, Conn., from 1948 to 1975 and served as medical director at Community Health Plan in Bridgeport. He was an instructor at Yale University School of Medicine and then served as an assistant professor at the Indiana University School of Medicine from 1977 until his death. He had been affiliated with Wishard Memorial, Methodist, Winona Memorial and Community hospitals in Indianapolis. Dr. Kaufman was medical director at Metro Health Plan in Indianapolis from 1976 to 1989, when he retired. He was a member of the board and president of the Central Indiana Council on Aging from 1977 until his death. He received the 1989 George Davis Award of the Interfaith Fellowship on Religion and Aging for noteworthy support and advocacy of programs designed to meet the needs of older persons.

obituaries

Larry P. Kays, M.D.
Dr. Kays, 52, an Evansville neurologist, died Nov. 10, 1995. He previously lived in Indianapolis.

He was a 1968 graduate of the Indiana University School of Medicine and a Navy veteran of the Vietnam War.

Dr. Kays was on the staff at St. Mary's Medical Center and Deaconess Hospital in Evansville.

Stewart B. Kephart, M.D.
Dr. Kephart, 78, a Bluffton obstetrician/gynecologist, died Oct. 15, 1995.

He was a 1943 graduate of the University of Pennsylvania School of Medicine and an Army veteran of World War II.

Dr. Kephart was on the staff of the Caylor-Nickel Medical Center in Bluffton from 1951 to 1989. He founded the clinic's department of obstetrics and gynecology, which he chaired for 38 years. He was a fellow of the American Board of Obstetricians and Gynecologists and a fellow of the International College of Surgeons. He had served as president of the Indiana Society of Obstetricians and Gynecologists and as past director emeritus of the Indiana Division of the American Cancer Society. He was a member of the American Association for Maternal and Infant Health, the American Fertility Society and the American Geriatrics Society.

Ivan T. Lindgren, M.D.
Dr. Lindgren, 63, an Aurora family physician, died Nov. 8, 1995, at his home.

He was a 1957 graduate of the University of Illinois College of Medicine and served in the U.S. Air Force from 1959 to 1961.

Dr. Lindgren, who had a practice in Aurora for 25 years, served as the Dearborn County health officer since 1971. He was medical director at many area nursing homes and performed all the physical exams for South Dearborn Pee Wee Football. Dr. Lindgren had been a physician with the student health service at Miami University in Oxford, Ohio, and was director of clinical development at Hoechst Pharmaceutical Co. in Cincinnati.

Georgianna Lutz, M.D.
Dr. Lutz, 97, a Hobart family physician, died Oct. 16, 1995, at Lincolnshire Health Center in Merrillville.

She was a 1924 graduate of the General Medical College in Chicago, Ill.

Dr. Lutz was a Gary area physician for 67 years and was a staff member of Ameritus at St. Mary Medical Center and Methodist Hospitals in Lake County. She was a member of member of the American Academy of Family Physicians and the American Medical Women's Association.

George B. McAleese, M.D.
Dr. McAleese, 72, a retired Terre Haute surgeon, died Sept. 9, 1995, at St. Francis Hospital in Indianapolis.

He was a 1946 graduate of the University of Pittsburgh School of Medicine.

Dr. McAleese was affiliated with Union and Regional hospitals in Terre Haute and had been on staff at the student health center at Indiana State University.

Linus J. Minick, M.D.
Dr. Minick, 74, a Churubusco family physician, died Nov. 3, 1995, at St. Joseph Medical Center in Fort Wayne.

He was a 1951 graduate of the Indiana University School of Medicine and an Army veteran of World War II.

Dr. Minick practiced in Churubusco from 1952 to 1993. He had served as president of the St. Joseph Medical Center staff and as an assistant clinical professor in Indiana University's Department of Family Practice. He was a diplomate of the American Academy of Family Physicians.

Adolph C. Predd, M.D.
Dr. Predd, 88, a retired LaPorte family physician and surgeon, died Aug. 29, 1995, at LaPorte Hospital.

He was a 1936 graduate of the Loyola University Stritch School of Medicine.

Dr. Predd was in practice for more than 50 years, retiring in 1985. He was a past president of the LaPorte County Medical Society and was affiliated with LaPorte, Holy Family and Fairview hospitals.

William J. Stangle, M.D.
Dr. Stangle, 89, a Bloomington radiologist, died Oct. 17, 1995.

He was a 1931 graduate of the Indiana University School of Medicine and a Navy veteran of World War II.

Dr. Stangle was the founder of Southern Indiana Radiological Associates. He served on the staffs of Bloomington Hospital and Dunn Memorial Hospital in Bedford and was a member of the board of directors of Blue Cross and Blue Shield of Indiana.

John R. Van Kirk, M.D.
Dr. Van Kirk, 75, a West Lafayette family physician, died Nov. 3, 1995, at his home.

He was a 1944 graduate of the Indiana University School of

obituaries

Medicine and a U.S. Army veteran.

Dr. Van Kirk had practiced in West Lafayette since 1961 and previously practiced in Burlington. He had served as regional medical director for the Lake Central office of State Farm Insurance Co., medical examiner at the Indiana Veterans Home, medical director of Tecumseh Area Planned Parenthood and city health officer for West Lafayette.

Roland E. Weitzel, M.D.

Dr. Weitzel, 78, a retired family physician and surgeon in Princeton, died Oct. 15, 1995, at Gibson General Hospital.

He was a 1943 graduate of Hahnemann University School of Medicine and a U.S. Army Medical Corps veteran of World War II.

Dr. Weitzel had practiced in Princeton for 35 years and served as chief of the medical staff at Gibson General Hospital. He was a member of the American Academy of Abdominal Surgeons and the American Academy of Family Physicians. ❑

Uncertain Times: Preventing Illness, Promoting Wellness

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February 7-10, 1996

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In these times of uncertain economic forces and rapidly advancing scientific knowledge, the stresses of keeping one's practice current and financially viable exact their toll on physicians. Physician health now includes a broad, pro-active, preventive approach of reducing all types of physician health problems and offering assistance before there is actual impairment.

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Presentations dealing with all aspects of physician health, including issues of well-being, impairment, disability, treatment, prevention and education are to be considered during the Conference. Topics of particular interest include: coping with changing economic practice circumstances; personal and professional stress and physician health; epidemiologic data; sexual boundary violations and other interpersonal problems; violence and physicians; women, elderly, minority, gay/lesbian, and other identified populations, among other issues.

Key Note Speakers will include:

Frances Conley, MD -	"Ruminations of an Academic Maverick"
Leah Dickstein, MD -	"Preparing Our Trainees for Healthy Living"
Ronald Shellow, MD -	"Diagnosis vs. Disability: Legal and Clinical Issues"

Pre-Conference Institutes will include:

Update on Chemical Dependency: Edward Senay, MD, - *Cocaine;* Robert Swift, MD, PhD - *Current Pharmacologic Management Strategies;* Norman Miller, MD, - *Assessment and Management of Dual Diagnosis*

Update on Psychiatry: Morton Silverman, MD, - *Suicide;* Dominic Ciraulo, MD - *Newer Antidepressant Drugs and Drug Strategies;* Eberhardt Uhlenhuth, MD - *Anxiety Disorders: Changes in Diagnoses and Management*

Women's Health, 1996: Erica Frank, MD, MPH - *Research Needs and Plans;* Carol Scott, MD, MPH - *Violence as a Healthcare Issue;* Michael F. Myers, MD - *Relationships and Other Mental Health Issues*

Recreation
When not discussing physician health issues, promote your own personal health. You will find an 18-hole championship golf course, several swimming pools, and tennis courts – two lit for night play. Enjoy jogging around the golf course, bicycling in the balmy southwestern breeze, horseback riding on the edge of town or working out at the nearby fitness center.

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Write, call or fax: International Conference on Physician Health , American Medical Association, 515 N. State Street, Chicago, IL, 60610, 800 621-8335, fax: 312 464-5826.

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people

Dr. Patrick Anderson, a Richmond internist, received the 1995 Paul S. Rhoads Humanity in Medicine Award from Reid Hospital. He was honored for his history of extraordinary care to patients, including giving free medication to an unemployed man who had no insurance.

Dr. James W. Hardacker and **Dr. Peter N. Capicotto** of The Spine Institute, with offices in Carmel and Beech Grove, have been certified by the American Board of Orthopaedic Surgery. Dr. Hardacker co-authored two papers presented at the 1995 Scoliosis Research Society meeting in Asheville, N.C. The studies were titled "Loss of Lumbar Lordosis in Uninstrumented Solid Lumbar Fusions" and "Safety and Efficacy of Isola-Galveston Instrumentation and Fusion in the Treatment of Neuromuscular Spinal Deformities."

Dr. Frank Wu, an Indianapolis allergist, gave a presentation on "Allergic Pollens in Indiana" at the annual meeting of the American College of Allergy, Asthma and Immunology in Dallas, Texas. The research was an award-winning project, and the poster was displayed as a special exhibit at the Dallas Museum of Art during the meeting.

Dr. Scott D. Gudeman of Specialty Centers for Orthopaedic and Rehabilitative Excellence (SCORE) in Indianapolis spoke on "Treatment of Plantar Fasciitis with Iontophoresis" at the annual meeting of the American Orthopaedic Society for Sports Medicine Conference in Toronto, Canada.

Dr. Steven F. Isenberg of Indianapolis was certified by the American Board of Otolaryngic Allergy. He spoke on "The Use of Interactive Video for Informed Surgical Consent" at the American Medical Writers Association annual conference in Baltimore, Md.

Dr. Rick C. Sasso, an orthopaedic surgeon with Indianapolis Neurosurgical Group, was a faculty member at a spinal instrumentation course sponsored by the Spinal Science Advancement Foundation in Memphis, Tenn. He lectured on anterior cervical plate and screw constructs and taught the practical bioskills workshop of anterior cervical plating.

Dr. Mark G. Richards, a Carmel family physician, received the Distinguished Young Alumnus Award from Indiana Wesleyan University. He is a 1977 graduate of Indiana Wesleyan.

Dr. Jane Howard of Nasser, Smith & Pinkerton Cardiology in Indianapolis spoke on "Psychosocial Aspects of CAD in Women" at the American Medical Women's Association meeting in Seattle, Wash.

Dr. Michael A. Kuharik and **Dr. Jeffrey I. Reider**, neuroradiologists with Premier Radiology Network in Indianapolis, have passed the Certificate of

Physician Recognition Award recipients

The following ISMA physicians are recent recipients of the AMA's Physician Recognition Award. This award is official documentation of Continuing Medical Education hours earned and is acceptable proof in most states requiring CME in re-registration that the mandatory hours of CME have been accomplished.

September 1995
Armbuster, Thomas G., Fort Wayne
Bright, Robert A. Mishawaka
Clark, Michael A., Indianapolis
De La Cotera, Frederick G., Munster
Delbello, Mark W., Fort Wayne
Farr, Jack, Indianapolis
Haber, Irving I., Terre Haute
Haerr, Robert W., Terre Haute
Hahn, Richard A., Indianapolis
Hatch, Stephen J., Fort Wayne
Heaton, Elton, Madison
Kaye, Robert C., Rensselaer
Lee, Thomas M., Hartford City
Lim, Young S., Evansville
Luce, John W., Michigan City
Mazdai, Abouzarjomehr, Connersville
Michael, John M., Indianapolis
Priddy, Marvin E., Fort Wayne
Rettig, Arthur C., Indianapolis
Van Hove, Eugene D., Carmel
Yolles, Elliott A., Indianapolis

October 1995
Ahler, Kenneth J., Rensselaer
Banning, Vernon P., Evansville
Czaja, Joseph T., Munster
Galup, Luis N., South Bend
Hathaway, William H., Auburn
Hogan, Michael A., Indianapolis
Kennedy, David B., Kokomo
Kight, Jerry L., Indianapolis
Kobak, Alfred J., Valparaiso
Ladowski, Joseph S., Fort Wayne
Larosa, Joseph A., Indianapolis
Lewckyj, Myron I., Valparaiso
Lucena, Bernardo S., Crown Point
Maxam, Beverly T., Indianapolis
Miller, Phillip M., Greenfield
Morera, Julio A., Evansville
Nasr, Suhayl J., Michigan City
Pugh, Newell O., Indianapolis
Schwartzman, Ilya, Columbus
Sturdevant, Frank M., Valparaiso
Sunkel, Daniel R., Lafayette
Tharp, Patricia W., Evansville
Wheeler, Jeffrey A., Fishers
White, Wayne B., Connersville

Added Qualification administered by the American Board of Radiology.

Dr. Alan F. Smith, a pathologist from Bedford, received a three-year appointment as cancer liaison physician for the hospital cancer program at Bedford Regional Medical Center.

Dr. Andrew J. Vicar of Orthopaedics Indianapolis wrote the continuing education article in the September issue of *Professional Medical Assistants Journal*. His article was titled "Casualties of the Keyboard, Computer Related Disorders of the Upper Extremities."

Dr. Frederick M. Kelvin, a radiologist with Methodist Hospital in Indianapolis, was a guest faculty member at a postgraduate course in Phoenix, Ariz., on abdominal imaging. He spoke on colorectal cancer, small bowel obstruction, colitis, principles of double contrast studies and female pelvic floor disorders.

Dr. William Beeson, an Indianapolis facial plastic and reconstructive surgeon, presented five lectures at the fall scientific meeting of the American Academy of Facial Plastic and Reconstructive Surgery in New Orleans, La. He wrote an article titled "Surgical Management of the Upper Third of the Face" for the October issue of *Cosmetic Dermatology*.

Dr. Steven R. Dryden, an Indianapolis anesthesiologist, and **Dr. Thomas J. Fischer**, an Indianapolis hand surgeon, were named to the board of visitors for the College of Pharmacy and Health Sciences of Butler University.

Dr. Ronald L. Peterson and **Dr. James S. Robertson**, retired Plymouth family physicians, were honored for their combined 81 years of service. The Marshall County Medical Society, St. Joseph's Hospital of Marshall County and the city of Plymouth recognized the physicians at a dinner.

Dr. Robert W. Haerr, a Terre Haute radiation oncologist, received the 1995 Weinbaum Award from Union Hospital. The award is given annually to a member of the hospital medical and dental staff who has provided outstanding service to the practice of medicine.

Dr. John C. Johnson of Valparaiso received the Emergency Medical Services Award for outstanding contributions in the field by the American College of Emergency Physicians. He is the administrative medical director for the emergency center for trauma and critical care at Porter Memorial Hospital.

Dr. Stephen M. Simons of South Bend was selected to serve on a team of sports medicine specialists who traveled to Australia and New Zealand to exchange ideas on sports medicine issues. He is a sports medicine specialist and faculty member of St. Joseph's

Patrick A. Dolan, M.D., Indianapolis, signs copies of his book, *The Indiana Roentgen Society: A History*. Dr. Dolan, who has held several offices in the Indiana Roentgen Society, including president and councilor positions, researched and wrote the book. The history, which was compiled from minutes and other available records of the society and from interviews with members, covers the period from Jan. 20, 1928, to May 13, 1995.

people

Medical Center's Family Practice Residency Program.

Dr. Gerald Kurlander, an Indianapolis diagnostic radiologist, and **Dr. John C. Lowe**, an Indianapolis gastroenterologist, received the 1995 Community Hospitals Indianapolis Fellowship of Distinguished Physicians Award. The award recognizes those who have distinguished themselves in the areas of education, research and patient care.

Dr. Chad C. Lamb of Anderson was named a fellow of the American Academy of Family Physicians.

Dr. Jeffrey C. Bird, a Muncie family physician, was named to the Delaware County Board of Health.

Dr. Edward R. Gabovitch, medical director of the Arthritis Care Center at Methodist Hospital in Indianapolis, received the Indiana Chapter Humanitarian Award from the Arthritis Foundation.

Dr. Franklin K. Beeler, an Anderson family physician, has retired after 42 years in practice.

Dr. Randall Braddom, professor and chairman of the department of physical medicine and rehabilitation at the Indiana University School of Medicine, was installed as president of the American Academy of Physical Medicine and Rehabilitation.

Dr. Peter F. Kunz, an Indianapolis plastic surgeon, donates his services at the Marion County Juvenile Center for any youth who wants to have a gang tattoo removed.

William L. Purcell was honored by the Vigo-Parke-Vermillion Medical Society for his 25 years of service as executive director of the society.

New ISMA members

Romel C. Antolin, M.D., Indianapolis, obstetrics and gynecology.

Thomas M. Armstrong, M.D., Indianapolis, internal medicine.

Ingrid E. Aufderheide, M.D., Columbus, ophthalmology.

William M. Bailey, M.D., Jeffersonville, cardiovascular diseases.

Eric A. Bannec, M.D., Bloomington, internal medicine.

Joseph H. Beaven, M.D., Charlestown, internal medicine.

Laurence W. Behney, M.D., Bloomington, family practice.

Kambiz Behzadi, M.D., Terre Haute, orthopaedic surgery.

Luis F. Bernal, M.D., Gary, internal medicine.

Karl J. Blessinger, M.D., Muncie, clinical pharmacology.

Stephanie A. Brazus, M.D., Indianapolis, family practice.

Daniel E. Brier, M.D., South Bend, pediatrics.

Paul E. Broderick, D.O., Martinsville, colon and rectal surgery.

Michael J. Brubaker, D.O., Rochester, family practice.

Blandine B. Bustamante, M.D., Fort Wayne, anatomic/clinical pathology.

Tim J. Conrad, M.D., Corydon, ophthalmology.

Wendy K. Corning, M.D., Bloomington, obstetrics and gynecology.

David DeSantis, M.D., Richmond, family practice.

L. Mark Dean, M.D., Lafayette, radiology.

Stephen P. Dewey, M.D., Indianapolis, family practice.

James G. Donahue, M.D., Indianapolis, obstetrics and gynecology.

Daniel C. Eby, D.O., Jasper, orthopaedic surgery.

Michael A. Eifrid, M.D., Plymouth, obstetrics and gynecology.

Melissa K. Essig, M.D., Indianapolis, pediatrics.

Edward P. Fox, M.D., Evansville, oncology.

Jennifer L. Gage, M.D., Crawfordsville, general surgery.

Richard W. Gates II, M.D., Indianapolis, obstetrics and gynecology.

Paul R. Gettinger, M.D., Bremen, family practice.

Prodyot Ghosh, M.D., Bloomington, internal medicine.

Tali Giveon, M.D., Muncie, neurological surgery.

Norman J. Goldbach, M.D., Richmond, urological surgery.

Jeffrey M. Goodloe, M.D., Indianapolis, emergency medicine.

N.T. Gopalakrishnan, M.D., Terre Haute, internal medicine.

Nav K. Grandhi, M.D., Lawrenceburg, gastroenterology.

Mark W. Graves, M.D., Evansville, nuclear medicine.

Mark D. Griffith, M.D., Lafayette, physical medicine and rehabilitation.

Salomon Grinspan, M.D., Richmond, anatomic pathology.

Lisa A. Gulyas, M.D., Fort Wayne, pediatrics.

Joseph P. Harmon, M.D., South Bend, obstetrics and gynecology.

Alice M. Hartman, M.D., Seymour, obstetrics and gynecology.

Michele L. Helfgott, M.D., Munster, obstetrics and gynecology.

Jeffrey B. Hiltz, M.D., Muncie, family practice.

Scott R. Hobson, M.D., Indianapolis, ophthalmology.

Robert M. Holmes, M.D., Lafayette, internal medicine.

Beve P. House, M.D., Fort Wayne, emergency medicine.

Steven W. Huder, M.D., Evansville, clinical pathology.

Beth E. Ingram, M.D., Richmond, diagnostic radiology.

Robert M. Irick, M.D., Bloomington, emergency medicine.

Frederick L. Jackson, D.O., Fort Wayne, family practice.

Jonathan R. Javors, D.O., Schererville, orthopaedic surgery.

Richard M. Johnston II, M.D., Fort Wayne, anesthesiology.

Tracy A. Kangas, M.D., Munster, ophthalmology.

Daniel P. Kellar, M.D., Terre Haute, family practice.

Alan Koester, M.D., Lafayette, orthopaedic surgery, hand surgery.

Mark B. Lampert, M.D., South Bend, cardiovascular diseases.

Chong C. Lee, M.D., St. John, thoracic surgery.

Philip B. Leeds, M.D., Jasper, anesthesiology.

Linda M. Lenahan, M.D., Vincennes, internal medicine.

Teresa L. Lovins, M.D., Columbus, family practice.

Reggie D. Lyell, M.D., Corydon, family practice.

Michael T. Macfarlane, M.D., New Albany, urological surgery.

Arthur N. Mack, M.D. Evansville, family practice.

Merlyn J. Malola, M.D., Kokomo, general practice.

Howard J. Marcus, M.D., Munster, obstetrics and gynecology.

Cecil D. Martin, M.D., Carrollton, Ky., family practice.

Laura M. Maves, M.D., Fishers, pediatrics.

Rick A. Meyer, M.D., Fort Wayne, gastroenterology.

Thomas P. Miller, M.D., Michigan City, family practice.

Scott R. Miller, M.D., Shelbyville, radiology.

Fernando R. Montoya, M.D., Jasper, internal medicine.

Thomas A. Morse, M.D., Richmond, emergency medicine.

Syed M. Nawab, M.D., Louisville, Ky., cardiovascular surgery.

Mark T. Nootens, M.D., Munster, internal medicine.

Joyce A. O'Shaughnessy, M.D., Jeffersonville, oncology.

David E. Pallares, M.D., Jeffersonville, allergy and immunology.

Kiranchandra M. Patel, M.D., Bloomington, family practice.

Pamela K. Peak, M.D., Indianapolis, internal medicine.

Randall J. Phillips, M.D., Fort Wayne, radiology.

Gavin J. Roberts, M.D., Fort Wayne, ophthalmology.

Magdy Zaky S. Rofail, M.D., Richmond, gastroenterology.

Matthew B. Roush, M.D., Muncie, family practice.

Boris Sagalovsky, M.D., Crown Point, cardiovascular diseases.

David E. San Miguel, D.O., Michigan City, anesthesiology.

Anthony D. Sanders, M.D., Columbus, otolaryngology.

J. Christopher Sartore, M.D., Evansville, family practice.

James M. Scheffler, M.D., Kokomo, internal medicine.

David W. Schetter, M.D., Plymouth, anesthesiology.

Brian M. Schnell, M.D., Huntingburg, anatomic pathology.

Steven N. Schroeder, M.D., South Bend, anesthesiology.

Joel M. Schumacher, M.D., Plymouth, family practice.

Mehul H. Shah, M.D., Indianapolis, family practice.

Vijay P. Shah, M.D., Merrillville, internal medicine.

Joseph M. Smith, M.D., Richmond, obstetrics and gynecology.

Aruna Somani, M.D., Munster, internal medicine.

Patricia W. Sontag, M.D., Indianapolis, obstetrics and gynecology.

Kenneth Sowinski, M.D., Union City, family practice.

Theresa A. Sowinski, M.D., Winchester, anesthesiology.

Frank L. Spendal, M.D., Cayuga, family practice.

Carol A. Stauffer-Munekata, M.D., Evansville, family practice.

Sara C. Strickler, M.D., Lafayette, obstetrics and gynecology.

Charles L. Tapley, M.D., Muncie, family practice.

Gurdarshan S. Thind, M.D., Jeffersonville, cardiovascular diseases.

Charles A. Tollett Jr., M.D., Huntingburg, general surgery.

Jon S. Uloth, M.D., Evansville, family practice.

Naresh K. Upadhyay, M.D., Highland, internal medicine.

Margaret H. Vickers, M.D., Evansville, anesthesiology.

William M. Vickers, M.D., Evansville, anesthesiology.

Dennis L. Wagner, M.D., Indianapolis, anesthesiology.

William C. Watson, D.O., Winchester, family practice.

Daniel L. Wegg, M.D., Ridgeville, general practice.

Thomas L. Welch, M.D., Columbus, psychiatry.

Jeffrey M. Wempe, M.D., Muncie, anesthesiology.

Angela R. Wheeler, M.D., Gary, family practice.

Bernhard P. Wiebe, M.D., Markle, family practice.

Wilson W. Wu, M.D., Indianapolis, internal medicine.

Alexandria J. Zaleski, M.D., Munster, dermatology.

Robert A. Zaring, M.D., Muncie, clinical pharmacology. ❑

classifieds

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PROGRESSIVE OB/GYN PHYSICIAN GROUP in northwest Indiana seeking BE/BC pediatrician. This is a busy established practice doing approximately 40 deliveries per month that wants to work together as an alliance. Our office is affiliated with three contemporary hospitals that all have state-of-the-art technology, a level II+ nursery, outstanding nursing staff as well as full-time anesthesia and newborn intensive coverage. Northwest Indiana offers a quality lifestyle and easy access to Chicago with all of its wonderful cultural and recreational activities. Excellent compensation and benefits package that is negotiable. Start immediately. Please send CV to The Woman's Wellness Center, Rhonda Volk, Office Manager, 9136 Columbia Ave., Munster, IN 46321.

OPPORTUNITY FOR PHYSICIAN – Established or newly licensed MD for the practice of general medicine. Share in the care of patient clientele. Opportunity for growth and for possible takeover of practice. For private and confidential interview, phone (317) 447-1412, Mon., Tues., Thurs., 9 to 5. Phone (317) 447-1693 after 4 p.m.

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